UNITED STATES DISTRICT COURT

IN THE DISTRICT OF IDAHO

SAINT ALPHONSUS MEDICAL CENTER - NAMPA, INC., TREASURE VALLEY HOSPITAL LIMITED PARTNERSHIP, SAINT ALPHONSUS HEALTH SYSTEM, INC., AND SAINT ALPHONSUS REGIONAL MEDICAL CENTER, INC., Plaintiffs, vs. ST. LUKE'S HEALTH SYSTEM, LTD., and ST. LUKE'S REGIONAL MEDICAL CENTER, LTD., Defendants.	Case No. 1:12-cv-00560-BLW Bench Trial **Witnesses:** **Jeff Thomas Crouch** **Scott Clement (Video)**
FEDERAL TRADE COMMISSION; STATE OF IDAHO, Plaintiffs, vs. ST. LUKE'S HEALTH SYSTEM, LTD.; SALTZER MEDICAL GROUP, P.A., Defendants.	Case No. 1:13-cv-00116-BLW

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REPORTER'S TRANSCRIPT OF PROCEEDINGS

before B. Lynn Winmill, Chief District Judge

Held on September 24, 2013

Volume 2, Pages 213 to 445

Lisa K. Yant
Idaho Certified Shorthand Reporter No. 279
Registered Professional Reporter
Federal Certified Realtime Reporter

United States Courts, District of Idaho
550 West Fort Street, Boise, Idaho 83724 (208) 334-1500

A P P E A R A N C E S

FOR PLAINTIFFS SAINT ALPHONSUS MEDICAL CENTER-NAMPA, INC., SAINT ALPHONSUS HEALTH SYSTEM, INC., AND SAINT ALPHONSUS REGIONAL MEDICAL CENTER, INC.

Keely E. Duke
DUKE SCANLAN & HALL, PLLC
1087 W. River Street, Suite 300
Boise, ID 83707

David A. Ettinger
HONIGMAN MILLER SCHWARTZ AND COHN LLP
2290 First National Building
660 Woodward Avenue
Detroit, MI 48226

FOR PLAINTIFF U.S. FEDERAL TRADE COMMISSION

Peter C. Herrick
U.S. FEDERAL TRADE COMMISSION
500 Pennsylvania Ave., N.W.
Washington, DC 20580

J. Thomas Greene
U.S. FEDERAL TRADE COMMISSION
600 Pennsylvania Ave N.W.
Washington, DC 20580

Henry Chao-Lon Su
U.S. FEDERAL TRADE COMMISSION
601 New Jersey Ave., N.W.
Washington, DC 20001

A P P E A R A N C E S (Continued)

FOR PLAINTIFF STATE OF IDAHO

Eric J. Wilson
GODFREY & KAHN, S.C.
One East Main Street
Suite 500
PO Box 2719
Madison, WI 53701

Brett T. DeLange
OFFICE OF ATTORNEY GENERAL, STATE OF IDAHO
954 W. Jefferson, 2nd Floor
Boise, ID 83720-0010

FOR PLAINTIFF TREASURE VALLEY HOSPITAL

Raymond D. Powers
POWERS TOLMAN FARLEY, PLLC
PO Box 9756
Boise, ID 83707

FOR DEFENDANTS ST. LUKE'S HEALTH SYSTEM, LTD. AND ST. LUKE'S REGIONAL MEDICAL CENTER, LTD.

Jack R. Bierig
Ben J. Keith
Scott Stein
Charles Schafer
SIDLEY AUSTIN
One South Dearborn
Chicago, IL 60603

J. Walter Sinclair
STOEL RIVES
101 S. Capitol Boulevard, Suite 1900
Boise, ID 83702

FOR DEFENDANT SALTZER MEDICAL GROUP

Brian Kenneth Julian
ANDERSON JULIAN & HULL, LLP
PO Box 7426
Boise, ID 83707

I N D E X

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PROCEEDINGS

September 24, 2013

****** COURTROOM CLOSED TO THE PUBLIC ******

THE CLERK: The Court will now hear Civil Case 12-560-S-BLW Saint Alphonsus Medical Center, Nampa, Inc., versus St. Luke's Health System for Day 2 of bench trial.

THE COURT: Good morning, Counsel. A couple of housekeeping matters before we resume the testimony. We must have bored the audience away, I guess. But I was going to indicate that, as I suggested yesterday, that I would allow live blogging, and if there was no objection from counsel. There, apparently, is no objection. Of course, anyone who chooses to live-blog will be subject to the same restraints that otherwise would apply in the courtroom, with no recordings, and no still or video photography, of course, would be allowed. I think that would cover the primary areas of concern.

Another area that came up, apparently, Mr. Stein was provided three of the four items that Mr. Crouch either has reviewed or has testified that he's reviewed or intends to testify today, but he was not provided the fourth. In fairness, I think the plaintiffs, then, are at a choice: either the testimony of Mr. Crouch either will be stricken or not allowed with regard to that fourth study. We will have to make him available later in the trial for

cross-examination by Mr. Stein after he's had a proper chance to review that.

So plaintiffs, it's your option. You can proceed in either fashion, either agree to have it stricken, or I'll provide it to Mr. Stein and make Mr. Crouch available for cross-examination later in the proceedings.

MR. GREENE: Your Honor, we are -- Blue Cross of Idaho is, actually, couriering that over as we speak. It took some time to find the fourth study. My recollection of the testimony yesterday was that Mr. Crouch was answering my question about how do physician costs compare in Idaho to other parts of the United States.

He mentioned various figures, and he provided the Court and counsel with the bases that he recollected was the source of information, and he mentioned Milliman studies, he mentioned various things, one of which was this fourth article. I am going to clean this up, momentarily. It turned out that, from our perspective, it was the Milliman study, which they have, right now, and which was produced to them in discovery months ago.

So if the Court does want to strike something, it seems to me it may be just the reference to that one article, which, I believe, is actually not particularly on point to the statement he was making to me yesterday.

THE COURT: Mr. Stein, you will have a daily, so

you can review it and determine what, if any, portion you feel needs to be stricken, and discuss that with Mr. Greene and work it out, and if you can't, I'll resolve it.

MR. STEIN: I can tell you right now, Your Honor, that the article from Dykeman, that I'm a little confused, because I think Mr. Greene said that's being couriered over, so it's something that wasn't produced, we don't have, and move that the reference to the Dykeman study be stricken. It doesn't really do me any good to --

THE COURT: No, and that's why I am suggesting that you will have the option to either review the transcript, request for portions of Mr. Crouch's testimony be stricken or cross-examine him. After that's been provided and you've had a chance to digest it.

MR. STEIN: Thank you.

THE COURT: Mr. Crouch, I will remind you you are still under oath.

And with that, Mr. Greene, you may resume your direct examination of the witness.

MR. GREENE: Thank you, Your Honor. And good morning, Mr. Crouch.

CONTINUED DIRECT EXAMINATION

QUESTIONS BY MR. GREENE:

Q. As previewed in this previous discussion, I do want to ask just a few questions that relate to your

testimony yesterday. Specifically, overnight, did you have the opportunity to review some of the materials that you relied upon when you told us yesterday your estimates of the difference in prices for physician services in Idaho versus the rest of the United States?

A. No, I didn't do any preparation last evening.

Q. Can you now tell me what the basis was for your estimate that physician service prices in Idaho were, roughly, 140 to 150 percent of Medicare?

A. The percentage of Medicare were higher than that, generally. But there was an article that came out talking about the *Health Affairs* article that came out this month. So it was an article focused solely on office visits and it listed maybe a dozen or a dozen and a half office visit codes. Compared those codes a number of ways that showed the deviation from the mean, showed the mean, and then I compared our own allowances to each of those codes.

Q. And at a high level, roughly, what was the comparison?

A. For the -- if you are looking at the table, I am just trying to recall it now -- two codes account for about 60 percent of all office visits. And for those two codes we are above the 95th percentile. We would be 135 to 140 percent of Medicare.

Q. So 95th percentile would be among the highest in

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the United States?
A. Correct. 5 percent or fewer of health plans would pay an amount greater than that.
MR. GREENE: And just for the record, I'm not planning on introducing this document, Your Honor, but if we can put it in the record.
BY MR. GREENE:
Q. This is an article by Baker, Bundorf, and Royalty entitled, "Private Insurers' Payments For Routine Physician Office Visits Vary Substantially Across The United States," and that's in the September 2013 issue of *Health Affairs* at 1583; is that correct?
A. Correct.
Q. You also mentioned yesterday, Mr. Crouch, that there was a risk-sharing contract which you had sought to enter into with St. Luke's, which they decided not to join. Do you recall that testimony?
A. Correct, yeah.
Q. And you mentioned, I believe, that they told you that that's because they didn't want to be in price competition with Saint Alphonsus. Do you recall that testimony?
A. Yes.
Q. I assume -- was there a conversation in which that statement was made to you?

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A. Yes. That would have been 2012 as we were preparing our ConnectedCare product to be filed with the Department of Insurance.
Q. Approximately when in 2012 was it?
A. I'm not recalling exactly. It would have been about the spring of 2012, I believe, and it was with Randy Billings.
Q. And who is Mr. Billings?
A. He is the director of payor contracting for St. Luke's.
Q. And was anybody else present at this conversation?
A. That conversation was a phone call I had with Randy as I was trying to press him to make a commitment on the ConnectedCare product. And I think I pressed him to a point of exhaustion, and he finally made that comment.
Q. Okay. And since you recollect, what specifically was his comment to you?
A. His comment was that "We do not want to compete with Saint Alphonsus on this product over price."
Q. Did he use words that he didn't want to get into a bidding war with Saint Alphonsus or words to --
MR. STEIN: Objection; leading.
THE COURT: Sustained.
BY MR. GREENE:
Q. Do you have any recollections of any of the exact

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terms he used?
A. Well, the exact term of they didn't want to compete with Saint Alphonsus over price is the most specific that he used. It came up in a less specific way on several other occasions. That was the most specific comment that I recall.
Q. Okay. Thank you.
Let me turn to, generally, how your business works, Mr. Crouch. Who are BCI's customers in the first instance?
A. Blue Cross of Idaho is a mutual insurance company, so our owners are our policyholders, and in that case our owners and our customers are the same.
Q. What is the role of employers in your business?
A. Employers in U.S. healthcare, generally, are the -- well, they are the predominant supplier of benefits, healthcare benefits, to residents of the U.S. So in that reference the employer would be the direct customer, and the membership within the employer would be an indirect customer. So the employer is paying the premium in that regard.
Q. And do you also have a business of administration of healthcare plans as distinct from being an insurer of healthcare?
A. Correct. We have a little over 400,000 members in our -- on the medical side, not -- I am excluding the dental

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side at this point. And something just less than half of that membership is to actually administered business, where the employer is not purchasing an insurance product from us, they're having us administer their benefit.
Q. And is there a significant difference between the two kinds of businesses in terms of the kind of healthcare services that you provide?
A. No. To the marketplace and to the physician community and the hospital community, they would not know whether a member that was being treated, that they were treating was a self-funded member or an insured member.
Q. What is a network, Mr. Crouch?
A. Network, I am assuming that's a reference to a provider network?
Q. Yes.
A. So in Idaho we have, for each product, take a PPO as an example, a PPO has a network of providers. That is the group of providers who, again, would contract with us to be in that network. So we would execute a contract with them; we would establish what the payment allowances would be; we had arrived at other agreements in terms of policies and procedures that we each would follow.
Q. What does it mean to be "in network"?
A. In network means that you have a contract and you are a contracted provider.

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Q. What does it mean to employees that something is either in network or not in network?

A. The importance for the employee is that the benefit designed, typically, has a higher out-of-pocket cost for a person who uses a noncontracted provider. And there will be two elements to that higher cost. One element is that the benefit design is such there is a 20 percent lower allowance for non -- well, the allowance is the same, but there is a 20 percent increase cost share for the member. In addition the member can be billed anything between our payment allowance and what the provider chooses to charge.

Q. And what do employers, typically, want from BCI in terms of the network?

A. Our network activities would be focused around, I guess, several items. One of them is we need to have a complete network. And in the case of primary care and hospital services, that would mean that we would have contracting providers in our network in that member's community. So that's the first requirement, is broad network access.

And the second -- a series of other requirements would be providers that we believe are of high quality. In some of our products we credential providers to attempt to test that quality issue. We want providers to be cost-efficient. So we want them to be good stewards of

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healthcare resources.

Q. And you mentioned that employers want physicians in community. Can you give more perspectives on that?

A. Correct. For primary care services, it's a threshold that a health plan would have to offer would be to have primary care services in the direct community that the member resides. For hospital services the same would apply, to the extent there is a hospital in that community. Specialty services become a little less specific.

Most members when they buy an insurance product or enroll in a product, they don't, necessarily, anticipate if they're going to need aggressive surgery, so it doesn't always occur to them to check to see if the specialists are in network. An informed consumer would; some folks would not. But everybody is concerned about primary care access in their community.

Q. So would it be the case that for the provision of specialty services versus primary care services, people might be willing to drive further or take more time to get to those services?

A. Yes, to some limit, but there is higher willingness of members to drive for specialized services.

Q. And when you begin a negotiation with an employer, do they, typically, indicate to BCI in the form of a request for proposal, or some other document, what they want from

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BCI in terms of the network?

MR. STEIN: Objection, Your Honor. I don't believe that he has established that Mr. Crouch is involved in negotiations with employers.

THE COURT: Let's lay that foundation.

BY MR. GREENE:

Q. Do you have knowledge of the negotiations that BCI carries out with employers?

A. Yes. For large employers my area is always involved.

Q. So you are directly involved in those negotiations with employers?

THE COURT: Counsel, I forgot. Mr. Crouch, you did testify about that yesterday as to the largest eight or nine hospitals that you were directly involved and oversaw the negotiations; is that correct?

THE WITNESS: That is correct. I think the question is around our clients, not our providers.

THE COURT: Okay. All right. I see now the distinction.

Go ahead, Mr. Greene.

BY MR. GREENE:

Q. You may proceed --

MR. STEIN: I apologize, Your Honor. I'm sorry. Did we establish, my objection was to Mr. Crouch's

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involvement in negotiations with employers, not with hospitals. That was the basis.

THE COURT: Mr. Crouch has corrected me on that score, and now I am allowing Mr. Greene to go back to lay a further foundation with regard to negotiations with employers.

BY MR. GREENE:

Q. So as I understand your testimony, Mr. Crouch, you actually do engage in negotiations with the ten or so largest employers in Idaho?

A. I'm not sure I put a number to the largest employers. I will give you a recent example: Three weeks ago I was scheduled to attend a meeting with Melaleuca, which is a large employer in Eastern Idaho. And anytime there's a large employer, State of Idaho, Melaleuca, Micron, Boise, Inc., there is always involvement from my area. It might not be me, personally, but my area is involved.

Q. Okay. And in the context of that involvement, do you see the documents that reflect what employers want from BCI in terms of the network?

A. Yes. When we have a lead that we are actively working, if it's a large enough lead, every major functional area in the company becomes involved in responding to a request for proposal. And the questions on that RFP, then, would be delegated out to each the departments, membership,

claims, customer service, provider services, correct.

Q. And as part of that process, do you occasionally do analyses of the proximity of physicians to the employees of that particular potential customer?

A. We do. It varies. If the employer is being consulted by a local broker, then the broker usually has a great deal of knowledge about our network, and the RFP will be somewhat streamlined. If the employer is out of state and they are unaware of the capabilities we have around provider contracting or medical management or other issues, then they would have a more complex set of questions.

Q. To what extent are you asked to provide information to the employer or potential customer of the proximity of primary care physicians to where the employees live?

A. For large employers out of state -- now there's a secondary category here, as well. In the Blue Cross/Blue Shield Association the Home Plan is the plan where the corporation's headquarters is located. And very often the Home Plan -- so let's say that it's Target, and Target is located in Minnesota, the Blue Cross plan in Minnesota would be the lead plan in that case, but there are Target stores across the country. So the Minnesota plan would then send out RFP questions to each of the plans that has a Target store in their location. And we'd be expected to complete

that RFP.

And it's very typically going to show -- ask questions around: Here are the cities our Target stores are located; compare that to your provider network. And very often they would say compare that to the provider network they are currently administering in their plan, United, CIGNA.

Q. Is that sometimes known as "a disruption study"?

A. Yes, that's what that's called.

Q. Do you do these all the time?

A. We do them regularly.

THE COURT: Could I ask why it's called "a disruption study."

THE WITNESS: It is trying to identify the extent to which Target's employees will be disrupted in their medical network. More typically, that is not a disruption study of specialists, again. That's to say the employees of Target on Eagle Road in Meridian are currently being administered -- so I am going to make this up as an example -- by CIGNA, and here are all the primary care physicians in the CIGNA plan. Now go compare that against the Blue Cross of Idaho primary care physicians and identify any areas where there would be a disruption in network.

BY MR. GREENE:

Q. And is it the case that sometimes you don't have

to do these kind of studies?

A. Correct. If it's an in-state employer and they are being consulted by an in-state broker, they're already aware of our network. And in that case, the broker would be communicating the disruption to the employer without our involvement.

Q. And this may be the obvious question: Obviously, you have knowledge of your own network; correct?

A. Correct, yes.

Q. So you wouldn't need to do such a study in order to make a judgment with regard to the proximity of primary care physicians to potential customers in a particular city?

A. We do it -- we do it out of form just to communicate the results, but we are already aware of what our disruption is.

Q. And how important is it to have primary care physicians close to potential employees?

A. It's a hurdle if you don't -- if you don't meet that one hurdle, then you are not considered an eligible vendor for the employer.

Q. So would it be the case that you would be, essentially, knocked out of the competition if you didn't have that?

A. Yes, that's correct.

MR. STEIN: Objection; leading.

THE COURT: Overruled.

THE WITNESS: So we have a few examples of that at Blue Cross of Idaho because our provider network is so broad. The most recent example of that would be in Twin Falls, in around 2004 to 2009, when we had 65 percent of the providers in Twin Falls under contract, but did not have the Physician Center, which is the local dominant primary care practice in Twin Falls, and we sold very little business in that market during that period.

BY MR. GREENE:

Q. So that put you at a competitive disadvantage; is that what you are telling me?

A. Yes. It puts us at a competitive disadvantage, and that raises the cost of healthcare in that market.

Q. Would you be at a similar disadvantage if you did not have access to -- or have in-network pediatricians?

A. Yeah, you would not attract any families with children.

Q. Let me turn to your negotiations with the providers. We talked about your customers that you sell insurance to, but let's talk about providers. What is the ideal mix of providers from BCI's perspective?

A. Are you referring to like a percentage of providers under contract or a category of provider in the network?

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Q. No. More what -- in terms of hospitals and their efficiencies, et cetera.

A. Well, if I were to describe our preferred network, it would be a network we would include all of the highly efficient providers in the market, for one. And we would have broad access for primary care services as a secondary measure.

One of the measures of efficiency is if a primary care physician, as an example, needs to perform a diagnostic workup on a member, that they would refer that diagnostic work to a nonhospital provider, which is commonly far less expensive than the hospital for laboratory tests, imaging studies, that sort of thing.

Q. Now, how are rates, reimbursement charges, determined between BCI and providers?

A. It varies. So I will start with the simplest method, which is for professional services. We establish fee schedules that we believe are appropriate in the market. We have a -- recognize that we need to have most of the professionals in the market under contract. So we have -- had a policy in the past that we realize we are going to need to pay above national allowances to attract those providers, but we want to hold it to a range that is still affordable for our policyholders.

So in that case we will establish fee schedules

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that we think are appropriate for physician services, physical therapy, audiology, optometry, just go down the list of professional providers and attempt to do research to make sure that we're establishing the correct allowances.

Then, annually, we would call select providers in; we'd go around the state, and we would hold meetings around the state. It's called our physician payment advisory council. And we ask those providers, we give them a preview of what we're planning to do over the next year. We ask for their input and, very often, receive good suggestions that influence our decisions.

Q. And to what extent does this process involve negotiations?

A. For hospitals, that is the common method for establishing a payment allowance is that there is a negotiated contract that exists, then, between Blue Cross and the hospital.

Q. And how about do you occasionally negotiate with physician groups in terms of their fee schedules?

A. We don't negotiate with them in the manner that I'm talking about for hospitals. We do include physicians in our planning process, so they influence the process. There are times when a physician group will drop out of our network, and at that point we would enter into somewhat of a negotiation around the elements that they find unacceptable,

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try to reach a reasonable compromise. And whatever compromise we arrive at then becomes -- it's rolled into our standardized fee schedule for the next year for all providers.

Q. So when you enter into these conversations with a physician group that may be dropping out of your network, what is the -- to what extent are options or alternatives to you to provide those services as part of that process?

A. Well, in the contracting world there is a term called a "BATNA," which is your best alternative to a negotiated agreement. And that's a primary function that anybody performs when they're performing contracting, is that they identify if this doesn't happen -- so let's say that we're negotiating with the gastroenterology group. If I'm unable to resolve this contract, what is my best alternative?

And the challenge I represented yesterday is that in Idaho it's composed of seven or so smaller markets around the state. Many of those markets have monopolies for certain services: orthopedic services, gastroenterology services, some markets even have tight limitations on primary care services. Almost every one of those markets has a single hospital in it.

And so when we look at the negotiation with the hospital, as an example, we try to identify if this doesn't

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happen, what is my best alternative? And in that case, there is not a reasonable alternative to have the hospital not in contract.

Q. And how does -- if you do not have an adequate BATNA, best alternative, what is the potential effect on the prices or the reimbursement levels that you would be willing to pay?

A. If we don't end up with an agreement with that provider, our payment allowances then, and we've had this happen, very seldom, but it happened in Idaho Falls in the early 2000s when Eastern Idaho Regional Medical Center dropped out of our PPO network.

We then calculate what is a standardized payment for a hospital, averaging the payments we make to all hospitals. That becomes the payment allowance we allow in that market. If a member utilizes that hospital, which is now noncontracting, we would pay the member our average allowance for all hospitals, the member then would be left to negotiate any difference between that amount and what the hospital is charging.

Q. And as part of your BATNA analysis, would you look at the possibility of being able to serve customers or employees in a particular location with physicians that might be located some distance away?

A. We, certainly, attempt to make that a point of our

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conversation with the employers, but they are almost always going to find that unsatisfactory.

Q. Did you run into a BATNA problem in the Magic Valley?

A. We did. Between, it would have been about 2002 or so, and 2009, the Physician Center in Twin Falls was not contracted with Blue Cross of Idaho for a PPO. The Physician Center is the only provider of primary care services for children, pediatrics. I believe there was only one other internal medicine physician in that marketplace, and they were the dominant provider of family practice services.

So what ended up happening for Blue Cross is that we sold very little business in that market between those years. We ended up selling the State of Idaho account, which is our largest account by a very large margin; they are more than 10 percent of our total membership.

The State of Idaho, as we sold the account, recognized that we had a physician network limitation in Twin Falls, and they instructed us to close out that gap. So that would have been around 2004 or 2005.

So we then were left with we had been in that market and had been willing to be a small niche player in Twin Falls because of concern that if we conceded to the aggressive pricing demands of the provider community, we

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would have to roll that out to the rest of the state. And there are reasons for that if you want to get into it.

But now we had the -- the issue dialed up because our largest employer account is now a statewide account, and they were instructing us that we needed to resolve that problem in Twin Falls.

Q. And was your customer, the State of Idaho or its representatives, pushing you in the direction of making sure you had services in Twin Falls?

A. Yes, they were. They were pushing us to enter into a contract with the physicians.

Q. I would like to show you a map; this is one of the demonstratives. It will take us just a moment.

THE COURT: While you are bringing that up, what's the acronym that you used?

THE WITNESS: BATNA.

THE COURT: BATNA?

THE WITNESS: Best alternative to a negotiated agreement. If you were to pull out any of the, sort of, standardized contracting, and this is not in reference to medical contracting, it's a strategy that says before you go into a contract negotiation, you should understand what your BATNA is because that informs you as to how willing you need to be to make concessions.

THE COURT: Thank you.

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BY MR. GREENE:

Q. Before you, Mr. Crouch, is a map of the Twin Falls area. I believe we got this from Google. Would you give that a quick look and tell me if that looks like an accurate reflection of the geography in that area?

A. Yep, correct, I agree with it.

Q. And Twin Falls is the purple thing in the lower-left. Is that the city you've been talking about?

A. Yes.

Q. Now, there are -- what did you have in your network in Twin Falls, itself, when you got this state contract?

A. So we had 64 percent of the providers in Twin Falls in network. And the Twin Falls area would have about 200 providers if you counted all categories of providers. That would be composed of -- in this case the real problem was the primary care services would be about 50 to 60 primary care providers in Twin Falls.

Q. So as a percentage of the available primary care providers in Twin Falls, how many were represented by the group you mentioned earlier?

A. So I'm going to give you a general answer. I have not looked at that number recently, so my memory is going to fail me a little bit. But of the 54 primary care providers, we might have had 10 percent in network and the remainder

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would have been out of network.

Q. And from your perspective, was that adequate or inadequate?

A. That was inadequate, and we knew that because we had no sales success in Twin Falls.

Q. Now, I notice that there are various cities that seem to be reasonably close. Did you have physicians under contracts in any of those nearby cities and towns?

A. Yes, we had a very strong presence in Jerome, in Burley, in Rupert. I'm not sure there are physicians in Buhl, Filer, or Kimberly. If there are there is maybe one in each market.

Q. Roughly, what is the distance from Twin Falls to Jerome?

A. Looking at the little chart at the bottom, it looks like it's maybe 15 miles between Twin Falls and Jerome.

Q. Now, in building your network, could you offer this large employer the alternative of sending their employees to Jerome? Would that have been adequate?

A. We attempted to do that. And so that would have been our normal sales process for -- what is that? -- a six-year period, is to say there are 50-ish primary care providers in Twin Falls. There are more primary care providers out of Twin Falls when you look at Jerome and

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Burley and Rupert. And Jerome and Rupert probably had 20 providers, and Burley had maybe 25 to 30 providers.

So we had more providers in this 30-mile region that were contracting than were noncontracting, but the employers in Twin Falls don't want to drive to Burley for primary care and neither would the patients of Twin Falls.

Q. So this proved to be not an adequate solution for you?

A. It was not an adequate solution.

This is recalling -- the map is triggering a memory for me. I worked in Seattle, as I mentioned earlier, and we were a very niched player in the Washington market. PacifiCare Health Systems, which is the dominant -- what was in Southern California the dominant capitated health plan. But in Seattle --

MR. STEIN: Your Honor, I'm sorry. This is nonresponsive to the question.

THE COURT: Sustained. It is not. The question is simply whether this proved not to be an adequate solution, I think.

MR. GREENE: An adequate solution here. I think he is providing an additional anecdote.

THE COURT: Mr. Greene, go ahead.

MR. GREENE: Okay. Thank you.

BY MR. GREENE:

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Q. Let's take -- momentarily here I'm going to ask you about your additional experience. So just to make sure I'm clear on this, so individuals who were covered under the State of Idaho contract just were not going to drive that 10, 15 miles from Twin Falls to Jerome?

A. Correct. They will use the Twin Falls provider, and they will pay the out-of-pocket, additional out-of-pocket costs that leads to.

Q. And if you could not have solved that problem for the State of Idaho employer group, would you be risking the contract itself?

A. Yes. We feel like that our contract would have been in jeopardy with the state.

Q. And why is that?

A. It's too much of a problem for a local marketplace for the State. So as they look at their -- they were willing to come to Blue Cross of Idaho because the savings we could offer in healthcare costs was so great. I'm not recalling the exact number, but it would have exceeded 10 percent savings.

So if you're the State of Idaho, and you're the largest employer, and you're physically constrained to 10 percent reduction in total healthcare costs, it's a big number. But there comes a point at which they get so much noise from their employees and the dependents of their

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employees that they're not willing to -- that offset is not satisfactory, so they would look for another option.

Q. And what steps did you take to fix this problem, close this network hole, if you will?

A. Well, in addition to the State being concerned, Senator Coiner, which was a local legislator in Twin Falls, became very active with our senior leadership, representing his constituents. We had the brokers in Twin Falls dialing up their efforts to get Blue Cross of Idaho and the Twin Falls physicians to reach an agreement.

And at that point Ray Flachbart, who was the president and CEO of the company, became personally involved in it. So we dialed up our efforts to a great extent around 2007, 2008.

Q. Did that have a financial consequence to BCI?

A. Yes. We ended up having to concede to pricing -- their pricing proposal, which was an 8 percent increase in fees.

Q. And what were you planning on providing before you were pushed into the 8 percent increase?

A. Previous to that agreement, we were hoping they would accept our physician fee schedule, our statewide physician fee schedule.

Q. And did that have any --

THE COURT: Excuse me. If I understood you

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correctly in your prior testimony, this, in turn, would have resulted in an 8 percent increase to all the other primary care physicians around the state; in other words, moving up that schedule for primary care physicians.

THE WITNESS: Correct. Over time that is how that would happen.

THE COURT: So you never have outliers, but you'd allow one community that has, say, reimbursement rates substantially out of sync with the rest of the state because of pressures from those local physicians?

THE WITNESS: Well, one of the limitations we've lived with in Idaho is the Any Willing Provider Law, which states -- and this was passed when managed care was sort of going across the country. And it states that a health plan has to offer the same contract terms to any willing provider in Idaho. So if we arrive at a payment level for a primary care doctor in Pocatello, and at higher than what we offer elsewhere, any other provider can demand the same rate.

THE COURT: Then regional, is there any factor built in for cost-of-living differences between Pocatello, Coeur d'Alene, Boise?

A. No, we do not have any.

THE COURT: I'm sorry. Go ahead, Mr. Greene.

BY MR. GREENE:

Q. Just to follow up on His Honor's question, did the

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increases you gave the physicians in the Twin Falls area affect rates in other parts of the State of Idaho?

A. They didn't immediately. There is no case law around Any Willing Provider Law and how it needs to be implemented over time. Our interpretation has been that if we arrive at a negotiated increase with an outlier in some marketplace, that we would then incorporate that into our standardized contract in the future contracting cycle. And that's what we did in this case.

Q. So let me make sure I understand your answer. So, in fact, the 8 percent increase you gave to the physicians in Twin Falls wound up being an increase for physicians all across the state of Idaho?

A. Correct. We implemented that particularly large increase over a two-year period.

Q. And is there a practical business reason why BCI would roll those higher physician rates out to other physicians?

A. We had the requirement from the Any Willing Provider Law, which we feel like we'd need to commit to. The more practical reason is that if we offer higher rates for a health system, a hospital system for primary care services than we offer for an independent primary care practice, that creates arbitrage in the market that would cause independent practices to join the health system just

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to obtain the higher payment.

Q. So that would create an incentive for physician groups to be acquired by hospitals?

MR. STEIN: Objection; leading.

THE COURT: I'm going to give counsel some leeway. It's a court trial.

Proceed.

Unless I think counsel is putting words in the witness's mouth, which I didn't perceive to be the case.

Proceed.

THE WITNESS: So let's take the example of a routine office visit, which is in the study I referenced yesterday. The predominant code is an 87; let's call it a $90 payment allowance. If we are paying St. Luke's Magic Valley owned physician $100, and we're paying an independent physician in the Magic Valley $90, that independent physician now has an incentive, a financial incentive, to be purchased by the hospital because there is a payment increase that would be an immediate result.

BY MR. GREENE:

Q. And who were you -- was there a principal negotiator on behalf of the physician group you mentioned in Twin Falls?

A. The principal negotiator would be Chuck Pomeroy, who is the chief financial officer for St. Luke's Health

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System, at the time.

Q. And was there a physician as well?

A. Kurt Seppi is -- was -- I think he may -- well, at that point Kurt Seppi was the lead physician for Physician Center.

Q. And Physician Center was the group that wanted the higher prices; is that correct?

A. Correct. They had not changed their name to St. Luke's at that point.

Q. And what is Dr. Seppi's role currently?

A. The leadership at St. Luke's is still a little unclear to us, but if I read a recent article, he is in charge of clinical affairs for owned physician practices, I believe. So chief medical officer for clinical activities, not hospital activities.

Q. So do you have any further knowledge of his specific role at St. Luke's?

A. Well, when St. Luke's purchased Physician Center in Twin Falls, he was the lead physician in Twin Falls. They, then, subsequently, promoted him to have that lead role for their entire corporate structure across Idaho. I don't know the details of his involvement outside of that.

Q. Do you have any concerns, Mr. Crouch, about the proposed St. Luke's Saltzer transaction?

A. Our concern with the Saltzer acquisition is that

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it appears to be a repeat of the Magic Valley acquisition, which is the accumulation of market power and the ability to then negotiate what we would consider to be unreasonable payment levels.

Q. And what -- in your parlance, what do you think of market power? What does that mean to you?

A. I don't know if this is like a purely economic definition, but I would say market power, in this context, is acquiring sufficient power that they can arrive at concessions from Blue Cross or other payors above what the market would otherwise sustain.

Q. Has Blue Cross done any calculations with respect to what it expects in higher charges from the St. Luke's Saltzer transaction?

A. There are two events that follow the acquisition of a physician practice by a hospital. One of them is that we see -- of course, we see the hospital would be getting the bill for those professional services. On the Medicare side, that will result in an immediate doubling of the office fee. So our fee for our Medicare Advantage product would double overnight.

While that's a big number, the more relevant number on the commercial side is what happens to what we call "ancillary services." Ancillary services are those services that are not professional services and not hospital

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services. So it's that whole category of other activities, diagnostic testing, physical therapy, that sort of thing.

The Saltzer Medical Group had, prior to its acquisition by St. Luke's -- and I think it may even be continuing for some period now -- they have their own laboratory, they have their own diagnostic imaging, they provide therapy services, they provide specialized facility services for colonoscopies and minor outpatient surgeries such as that.

When we learned of the acquisition or the pending acquisition, we calculated what would happen to the cost of those ancillary services following the acquisition, and we calculated that for commercial services it would go up somewhere in the 30 to 35 percent range. And for Medicare Advantage --

MR. STEIN: Your Honor, we object to this, first of all, on foundation grounds, but also relevance. We are talking about Medicare, which is not a commercial product, which is -- this case involves commercial products. The ancillary services, which Mr. Crouch just testified, are neither professional services nor hospital services, which is the only two types of services that are at issue in this case.

MR. GREENE: Well, actually, that's not correct, Your Honor.

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THE COURT: Mr. Stein, you are suggesting that an increase -- so ancillary services, I guess Mr. Crouch did say those were nonhospital services; correct?

THE WITNESS: Before an acquisition they're not; after an acquisition, they become hospital services.

THE COURT: I'll overrule the objection.

Go ahead and proceed.

MR. GREENE: Thank you, Your Honor.

THE COURT: Just so I'm clear on this, in other words, they are ancillary services before the acquisition because the doctor, at that point, would then direct that the labs, diagnostic imaging, and whatnot, could be performed anywhere; after the acquisition it would be directed more within the hospital structure.

THE WITNESS: Correct.

THE COURT: Is that what you meant?

THE WITNESS: Yes.

THE COURT: All right. Go ahead and proceed.

MR. GREENE: Thank you, Your Honor.

BY MR. GREENE:

Q. Before you, Mr. Crouch, is a binder of materials. I would like to have you look at the first document, which is Plaintiffs' Exhibit 1302, if you would glance at that, and I will ask you some questions.

A. I have got it, yep.

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Q. If you would bring up 32.

So, Mr. Crouch, what is this document?

A. This is the source of the statistic I was giving earlier. This identifies the increase to policyholders following the acquisition of Saltzer by St. Luke's.

Q. Does this calculate that for both your Medicare Advantage program and your commercial programs?

A. The first page shows the Medicare Advantage program, and the second page shows the commercial program.

Q. And was this -- what is the data that was used to prepare this document?

A. We took a set of all the claims that Saltzer had billed us for in that category of ancillary services, and you can see they are listed on that first column. DME is durable medical equipment.

Q. We're just going to lay a foundation for the document. So what sort of -- this was based on claims data from Saltzer itself; is that correct?

A. Yes. It's the Saltzer claims, yes.

Q. And, roughly, how much data were you -- how far back did you go to create this?

A. September 2011 through August 2012, one-year period.

Q. Now, was this prepared in the ordinary course of BCI's business?

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A. Yes, as soon as we -- it's not a report we would produce monthly, but upon announcement of an acquisition it would be a common report.

Q. Now, I would like to turn your attention to what I believe is the third page, and my colleague will bring up the third page.

A. I have it.

Q. What is this showing us in terms of ancillary services?

A. The first two pages show the result. We had to make some assumptions about how many of the ancillary services that had been billed by Saltzer would begin to be billed by the hospital. This page -- and so to make that assumption, we had to figure out, well, in past acquisitions, do they tend to leave some of the services at the physician's office and move some of the services over to the hospital or what percentage of that movement occurs. This document gave us that data.

Q. And I notice in the first column there is something for Ada County. What is that describing in terms of shifts in service?

A. The first row of data is July of 2011; that's what the 2011/07 represents. And in Ada County the physicians --

THE COURT: Just so I'm sure, this is just Saltzer Group-generated patients who require these ancillary

services; correct?
THE WITNESS: And this is not. In this case, these are the physicians that had been acquired by St. Luke's before Saltzer.
THE COURT: Okay.
THE WITNESS: So we wanted to identify when St. Luke's acquires a physician office, how aggressive are they at transitioning those services into the hospital.
THE COURT: I'm sorry, I lost -- I knew there was something I was missing and now I see. So these were physician groups acquired prior to the Saltzer transaction?
THE WITNESS: Correct. On the first row it was 105 physicians.
THE COURT: And what you're tracking is, essentially, their transition using nonhospital sources for these ancillary services and converting and going over to hospital-provided services.
THE WITNESS: Yes.
THE COURT: Go ahead.
BY MR. GREENE:
Q. So what does this column show us for Ada County?
A. It shows us that following acquisition, essentially, all of the physician-billed services transitioned to the hospital.
Q. And was that also true for Canyon County?

A. Yes. And you can see that that's, certainly, smaller dollars for Canyon County; there hadn't been many acquisitions. But it, again, drops to almost zero.
Q. And is this -- I believe you mentioned that 105 physicians were reflected in these referral pattern shifts; is that correct?
A. At the top of the chart it was 105. By the time we arrive at the bottom of the chart, it was 156. So it grew, the volume of physicians grew by over 50 percent.
Q. Now, let's turn to the second page, which I think you were about to give us more detail on. What is this chart showing us?
A. This chart is showing us the repricing of the claims that had been previously billed by Saltzer and what the price would be if they were billed by St. Luke's Boise.
Q. And what is -- why is there a difference between services provided by a hospital-owned doctor group versus an independent doctor group?
A. So it is one of the challenges of the U.S. healthcare system. The foundation for the payment mechanics that were established a couple of decades ago have still been prevalent in the market, even though the market has changed to a different practice of ownership. So I will give you an example.
In the '80s, '70s and '80s, certainly, hospitals

were, at that point, specific centers for acute care activities. And the hospital would approach the payor and say: We're open 24 hours a day, seven days a week. We've got people who are in inpatient beds who need acute care, and they need their diagnostic testing performed. We can't perform a lab test in that environment with the same level of efficiency as a freestanding lab can because the freestanding lab is working 9:00 to 5:00, Monday through Friday. The same thing would apply for a free-standing outpatient --
THE COURT: Just so I'm clear, in terms of efficiency, the argument is they have to be staffed 24/7 even though probably two-thirds of the time the actual demand is fairly low because they're just waiting for an emergency to happen. Is that the concept?
THE WITNESS: I'd say there's an additional element, as well. So, one, is they have to be staffed all day long; and the second is the volumes are low. Traditionally, a hospital might have -- let's say that it's a hospital the size of a standard community hospital -- they might have 20 to 50 patients in-house on any one day. There aren't that many lab tests you're going to do for 20 to 50 patients, but you still have to have the equipment and staff to do it. So it's a combination of having to work all the time and having low volumes.

BY MR. GREENE:
Q. Now, these rates, is there any legal requirement that you pay higher rates for physician services and associated lab services done in a hospital-owned physician group?
A. No, there is no legal requirement.
Q. So this would be a matter of negotiation?
A. That's correct.
Q. Conversely, are there legal requirements in the Medicare system that require you to pay more for services provided by physicians in the ancillary services if they are provided under the Medicare program?
A. No, there are no requirements. There are many markets that pay less than Medicare for physician services.
Q. Okay. I would like to just get a sense of these prices. So we're going to call up a few of these. Let's start with drug --
THE COURT: Can I just -- and I apologize. Hopefully, I won't have to interrupt as often as I get a little better feel for some of the background. Can we use the word -- is the word "ancillary services" kind of a general term used within your business area which would include diagnostics, x-rays, labs, essentially, all of the services outside of a patient room for inpatient treatment and the kind of services that would be ordered by a

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physician on an outpatient basis?
THE WITNESS: I think that is a fair definition.
THE COURT: But not necessarily including pharmaceuticals, drugs, which might be just treated separately, or is that also considered an ancillary service?
A. It depends on the drug. There are drugs that can be --
THE COURT: Prescribed.
THE WITNESS: Right. So if it's prescribed and you use your pharmacy card, and you go to Walgreens, or wherever, that would not be an ancillary service. But if you're being injected with a drug as part of another activity, then that would be considered part of an ancillary service.
THE COURT: Go ahead, Mr. Greene.
BY MR. GREENE:
Q. So briefly, why would drug prices go up by, roughly, $78,000?
A. In the example of drugs -- I just want to make sure. We didn't show on this table what the new allowance would be. You would have to add current allowance plus increase in allowance. That would be the new allowance, so we're not showing on this sheet the new total.
In this case, the cost of drugs would grow by something like 130 or 140 percent.

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When a physician bills a drug through their office, it hits a standardized fee schedule for Blue Cross. And that fee schedule we've been able to manage to be representative of what we think is an appropriate price for the drug. When that is billed by the hospital, that is the result of whatever the negotiated agreement is with the hospital. And in that case you can see that it's an increased allowance.
THE COURT: And again, this would be a drug that is actually administered at the clinic, at the Saltzer clinic postacquisition?
THE WITNESS: Yes.
THE COURT: As opposed to a prescription which you would fill at a pharmacy which would be under the normal --
THE WITNESS: That is correct.
BY MR. GREENE:
Q. Just so I'm clear on this, Mr. Crouch, if this drug were administered in the before/after world would this be the same treatment, the same drug?
A. Correct. We took the claims -- so let's say that it's a tetanus shot or it's a hepatitis vaccine or something along those lines, something that's very commonly distributed through the physician's office. We took that drug and simply repriced it. We didn't assume there was any change in utilization, we didn't assume that there was a

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change in the drug. We simply took the list of drugs that Saltzer had billed us, repriced those drugs on the St. Luke's fee schedule.
Q. And then turning to the labs, which it's a $606,000 increase. What is the basis for that increase?
A. That would be another example of the fees at the hospital being a -- that we would pay which are higher than the fees we would pay to the physician in practice. So labs would include a complete blood count, cholesterol screenings, urinalysis, other blood work.
Q. And then turning down to PT/OT, that shows $165,000 increase. What is "PT/OT"?
A. Physical therapy and occupational therapy.
Q. And what is the basis for this price increase -- or this increase?
A. It would be the same basis, which is we have existing fee schedules that when the physician bills for the service, it's going to hit our standardized fee schedule, and when the hospital bills for the service, it's going to hit whatever its negotiated fee schedule is.
Q. One down from that is something called "RVU". What does "RVU" stand for?
A. Relative value unit. In this case it's a catch-all for an item that has a relative value unit, so it's a CPT code. It's a defined service, but it was just

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not bundled into any of the other summaries.
Q. I think you're going to need to uncap that for me. So what is -- what for a layperson would be an RVU, and what for a layperson would be a CPT code?
A. So I have not looked at this in a long time, but there are -- in the coding system there's what is called a HCPCS code, Healthcare Common Procedure Coding System. It's 7,000 codes that are not considered professional services, and in this case would also not be separately identified as being a lab or being drugs or being durable medical equipment. So it would be those items which are still reimbursed on an RV, on a relative value scale, but don't cleanly fit in one of the other categories.
Q. And TC Imaging for $589,000, what's that?
A. So this would be x-rays and MRIs and CT scans. TC is a reference to the technical component. For most codes there's going to be two components to the code, the amount we are paying for professional services and the amount we are paying for technical component, which would be the facility, as an example.
So we have a CT scan that has a $600 payment allowance. Some portion of that payment allowance is for the professional read of the exam, some portion of that is simply for the equipment, for the CT scanner, for the technician's time and for the facility time. So the TC is

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the nonprofessional component of imaging.

Q. And then dropping down to the grand total, I assume that reflects an addition of all of the estimated increases?

A. To some of the above numbers.

Q. So you've got it in dollars and in percentages. What are those dollars and percentages?

A. $2,476,000 increase for one year of these services that had been billed by Saltzer that we believe would be billed by St. Luke's, and that would represent a 32 percent increase in our costs.

Q. Let's turn to the first page.

THE COURT: Can I go back to this and ask one more question. The current charges is what the physician or the service provider is going to charge; correct?

THE WITNESS: Yes, that's correct.

THE COURT: And current allowed is what Blue Cross is going to pay?

THE WITNESS: Yes.

THE COURT: The rest of it could be subject to negotiation between the patient and the provider or it would be written off in some fashion; correct?

THE WITNESS: It would be written off if it is the contracting provider.

THE COURT: Now, the estimated increased

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allowance, what that suggests is that, for example, taking the colonoscopy, there would be a fairly modest increase in the allowance for that change, but the others would be -- so the real relevant or the important factors to be looking at are the last two columns; correct?

THE WITNESS: Yes.

THE COURT: All right. Go ahead, Mr. Greene. I just wanted to make sure I understood that.

BY MR. GREENE:

Q. Now, turning to the first page of this document, which will also be appearing on your screen, Mr. Crouch, what is this document reporting?

A. This is the same study, but we've replaced Medicare Advantage data for claims for commercial data.

Q. And I want to go back to this question. So this is under the Medicare Advantage plan. That's a Medicare program; is that correct?

A. Yes. So in the Medicare world there are two broad ways that a senior citizen in a community can obtain their Medicare benefits.

MR. STEIN: Your Honor, object. The question was answered.

THE COURT: True. But I am going to give a lot more leeway. This is a court trial, not a jury trial, and I'm going to give counsel a lot of leeway; otherwise, we're

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going to get bogged down pretty quickly here. So I will overrule the objection.

Go ahead.

THE WITNESS: Medicare's had for -- since the '80s has had the initiative to transition people out of the Medicare fee-for-service world and into what is called the Medicare Advantage, because the Medicare program can save money when members move to a Medicare Advantage plan, and they can obtain enhanced benefits.

So Blue Cross of Idaho is a contractor with the Federal Government in Idaho to be a replacement for the Medicare program. It is voluntary, but any member who elects our coverage, they get Medicare coverage through Blue Cross of Idaho and drops their direct coverage through the Medicare program.

BY MR. GREENE:

Q. Dropping down in this chart to "RVU, E&M".

A. Yes.

Q. Is this showing a $1.16 million increase?

A. Correct. And you can see on that item it was a raw assumption that the allowance for the professional service will double. Under our contract with St. Luke's, we follow Medicare pricing rules for physician office visits, and Medicare has had this nuance loophole in their program for when a physician's practice becomes acquired by a

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hospital, the hospital can then bill a supplemental charge for that visit, and it essentially doubles the cost.

Q. So would it be the case that the receptionist stays the same, the magazines in the waiting room stay the same, the doctor stays the same, the nurse stays the same, but the price doubles; is that correct?

A. That is correct.

Q. And what is RVU, E&M?

A. Evaluation and management that -- the industry jargon for an office visit.

Q. So is part of this something called a "facilities fee" or something else?

A. On that third column, where you saw the E&M fee double, that is what we typically refer to as the facility fee. The professional fee is still in place, and the hospital is now billing a facility component to that office visit, and so that -- that is one of the uses for the term "facility fee."

Q. Thank you. And then dropping down to the bottom line, what is that?

A. It shows that the cost for those services will grow by 1.2 million, which is a 43 percent increase.

Q. We do have a demonstrative. I can represent to you, Mr. Crouch, this was a demonstrative taken from a MedPAC report on Medicare payment policies from April of

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last year. Are you familiar with this document?

A. Yes, I have seen this before.

MR. STEIN: Your Honor, I am wary of testing the Court's patience, but we're talking now about Medicare reimbursement, not commercial reimbursement, which is the issue. This case only involves commercial plans.

THE COURT: Mr. Greene.

MR. GREENE: This is just context, Your Honor. I am going to ask two questions, and we're done.

MR. STEIN: With due respect, we -- well, first of all, we've objected to this demonstrative and because this is referring to a payment methodology that is a function of Medicare policy, not commercial reimbursement, which Mr. Crouch has testified is the subject of negotiations between the parties. This is the provider-based billing issue, Your Honor, that we --

THE COURT: All right.

Mr. Greene, the only possible relevance I could see to this would be that if there is a reason for not approving the acquisition, would be some overall increase in prices totally apart from the question of concentration of market power or competitive loss of competition. So I'm not sure why this is relevant.

MR. GREENE: Our view of this, Your Honor, is that we're trying to paint a picture of overall impact. And what

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this will show is that -- this, essentially, illustrates the doubling in price that Mr. Crouch just spoke to. This is a direct consequence of the transaction. It is a consequence also of a regulatory scheme that the federal government has.

THE COURT: It may be a consequence, but it is not a competitive consequence. I'm not sure it is a relevant consequence. So I think I will sustain the objection so we stay focused on -- you know, I'm sure the consumer would be very concerned, but that is not the concern of this litigation.

MR. GREENE: Thank you, Your Honor.

BY MR. GREENE:

Q. Now, Mr. Crouch, your analysis or BCI's analysis of the effect on commercial payments, is that based on -- what experience is that based on in terms of why you think this chart is relevant to or appropriate to be considered when considering the effects of the Saltzer/St. Luke's transaction?

A. It measures the impact we had already observed from the 150 previous acquisitions and applies that learning to the Saltzer acquisition.

Q. Is one of those experiences the experience with two orthopedic practices in Boise?

A. Certainly, the Intermountain Orthopaedics Group was acquired and one of the other surgical practices --

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well, more than one surgical practice were acquired, and we saw similar results through those acquisitions.

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Q. I would like to bring up the next document in order, Clinton, which is Plaintiffs' 1298.

What is this document, Mr. Crouch?

A. This is showing the -- do you want me to talk about the top half and the bottom half?

Q. Well, just describe the document generally, and then I may ask some questions about the bottom half of the first real page.

A. The top half is showing the changes in our -- we have two standardized fee schedules in the marketplace. Multiple conversion factor of fee schedules tend to benefit specialists. Single conversion factor tends to benefit primary care. There is a whole dialogue about that, if there's interest in that in this trial.

Q. Now, briefly, tell me what this shows.

A. It shows what the payment changes have been over time. You can see the years represented and the changes in the reimbursement.

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Q. This is a reflection of your ongoing payments at the higher level; is that correct?

A. Yes.

Q. And looking at the lower block -- which I will ask my colleague to highlight for us -- so are these annual figures? What period is covered by this?

A. 2008 through 2012. And this is showing that for ambulatory surgery centers -- we had mentioned earlier, in my testimony, that our understanding is that within Idaho, payment allowances are very high. That applies to professional services and hospital services. In this case, there would be another category included here, which would be surgery center services. During that period of time, those four periods represented, there is only one period when we made a payment increase. For St. Luke's Boise there were payment increases every period.

Q. So what is the bottom-line figure for these transactions, from your perspective, based on this chart?

A. This is giving a little bit of history over the increases. The bottom line is the -- when a surgery center is acquired by St. Luke's, our payment for all of those surgeries increases 289 percent.

Q. Thank you. Briefly, in terms of foundation, how was this prepared?

A. Similar to the method we used previously. We will

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take a set of real-life claims, existing claims that were paid, in this case it would have been through the surgery center, and we'll reprice those claims under the hospital's contract and calculate the difference.

Q. So conceptually, is this similar or the same as the calculation you did for the St. Luke's/Saltzer transaction?

A. Yes, same methodology.

Q. I would like to turn to the next exhibit, which is Plaintiffs' 1299. What is this document, Mr. Crouch?

A. Again, going back to the contracting process, at the beginning of each major negotiation, both parties will come together and try to identify what it is they're trying to accomplish through the negotiation. This set of slides is background for the -- what Blue Cross is trying to accomplish, which was really to communicate St. Luke's is overpaid for their services and we don't feel like the large increase is substantiated.

Q. How were the numbers within this slide deck calculated?

A. Well, there might be different methods based on the different slides. Do you have one in mind? Do you want me to look at it?

Q. Sure. Why don't you take a look at Slide 3.

A. Okay. So this slide shows the historical

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increases for their three largest hospitals for each year, and you can see the increases there in front of you. The point we were attempting to make with this slide is that the last column shows the hospital producer price index. That is a measure of inflation for the hospital industry. Similar to CPI for consumers, this is a measure of inflation for hospitals.

Q. Directing your attention to the Magic Valley column -- my colleague will highlight that portion -- starting in 2009, does this reflect the greater power in the Magic Valley that we discussed earlier?

MR. STEIN: Objection; leading.

THE COURT: Overruled.

THE WITNESS: Certainly. It shows that in -- the Magic Valley Hospital received an 8 percent increase in 2009; that was in an environment when inflation was 3.4 percent, nationally. That is not an amount we would have offered to any other hospital.

BY MR. GREENE:

Q. And then the -- in the subsequent year what was the figure?

A. 6 percent for the Magic Valley.

Q. And how does that compare to medical inflation?

A. In this case, you can see that this is the tail end of the recession, that inflation was dropping that year,

went to 2.2 percent.

Q. Now, I just want to understand how this works. So is the 6 percent in 2010 on top of the 8 percent in 2009?

A. That is correct. They are compounding numbers.

Q. And that would be true for the 2011 figure of 6.5, that is on top of the preceding 6 and the preceding 8?

A. Yes, exactly.

Q. Just very briefly, the St. Luke's facilities in Boise and Meridian, not as dramatic, obviously, but how did those compare, briefly, with medical inflation?

A. I don't think there is an example anywhere on the page where the increase is less than inflation, except for the Wood River reduction, but that was a request St. Luke's made of us; that was not our proposal.

Q. Turning to Slide 5, what is the purpose of this slide?

A. We were trying to make several points during this part of the negotiation. One of the points is that we felt they were attempting to resolve cost inefficiencies through higher payment increases. So the parlance we used is you're trying to solve a cost problem with a revenue solution.

And in this slide we're showing SLWR, St. Luke's Wood River, their average cost per inpatient day being $1,900, and you can see the -- compare that to EIRMC, who we typically hold out in Idaho as being a highly efficient

provider, their cost being $800 per inpatient day.

Q. So more than double?

A. More than double.

Q. Do you regard St. Luke's as an efficient provider of care?

A. No, we do not.

Q. And why is that?

A. This is -- one indication is there their cost structure is high. The second indication is what we've been talking about all morning, which is they redirect commodity services from a low-cost setting to a high-cost setting, so that is a substantial cost driver.

Q. And that's a consequence of acquisitions?

A. Yes.

Q. And how do they do in terms of Medicare?

A. I don't know if we have a slide here, but at that same meeting we are, essentially, debating whether they were efficient or inefficient for costs, Randy produced a slide from the Idaho Hospital Association that showed that St. Luke's was losing 20 to 25 percent on Medicare business, so this would be not Medicare Advantage but the Medicare system from the federal government.

And their own slide -- we brought it to his attention -- there on their own slide it showed that 75 percent of hospitals in Idaho are near or break-even or

are making money on Medicare. So his own slide, which he intended to show "look how much of an increase we need from you," demonstrated that their problem was cost, it was not revenue.

Q. I would like to have you turn to Slide 8. What was this slide designed to show?

A. Two points. The first point is that we have a category of services that we call "commodity services," which are those services where there is no perceived or measurable difference in quality. The only difference is in the payment allowance, and these are all examples of what we would consider to be commodity services. It is a scattering of different categories; I don't know if there is any particular thought put into what comes on this slide. But it was intended to show that despite the fee schedule improvements we had over many years with St. Luke's on the outpatient side, they were still an outlier in cost for most categories of services.

Q. And would these be the services that would be called upon by formerly independent physicians?

MR. STEIN: Object to the form.

THE WITNESS: Yes, every one of these services. You know, we were talking about drugs earlier, and there's an example of a drug on the very bottom line there, ondansetron hydrochloride.

BY MR. GREENE:

Q. Let me turn to the next exhibit in order, which I believe is Exhibit 1300. What is this document showing us?

A. We call this our conversion factor report, and it is a method we use to compare the reimbursement between hospitals in Idaho.

MR. GREENE: I would ask my colleague to highlight the St. -- one of the St. Luke's facilities.

MR. STEIN: Your Honor, we object to the use of this document. The basis for the objection is we think it is frankly evident from looking at it. You can see, Your Honor, that Blue Cross has selectively disclosed certain portions of some analysis that they did. You can see there's whole columns blacked out here, there's whole rows blacked out here. This version has what they did blacked out. We didn't get the backup for this; we didn't get the queries they ran for this. We have had absolutely no way to review the underlying analysis here. It is being presented as here is something we did, and here are our conclusions.

THE COURT: Mr. Greene.

MR. GREENE: I think, Your Honor, there are probably two levels. Firstly, they did discuss this with BCI, did not take the opportunity to do a motion to compel. We think that Mr. Crouch can certainly speak to the underlying data analysis that was done to support this.

From my perspective, this suggests that, over time, St. Luke's -- and I think this is the key point -- St. Luke's facilities had apropos at the efficiency point, gone up and over the efficiency point. Have gone from some with basically, middling-level cost levels to the highest in the state of Idaho in, roughly, a five-year period. So we think it's useful evidence.

THE COURT: Why was some of it blacked out?

MR. GREENE: This is a very detailed slide, what -- as I understand it -- BCI did not want St. Luke's to see the prices and costs associated with other facilities as part of the negotiation process. I think they could have brought this to the Court's attention in a much more timely way.

THE COURT: I am assuming the plaintiffs do not have the underlying data?

MR. GREENE: We do not.

THE COURT: You have what we see here?

MR. GREENE: I just have this.

MR. STEIN: To be clear, Your Honor, this redaction was a decision made by Blue Cross. This is a document that is produced as part of the -- as part of the discovery, and --

THE COURT: Well, at this point let me hear -- again, fortunately we don't have a jury here. I want to

hear how this was put together, why the matters were deleted, and then, Mr. Stein, you can inquire, perhaps, in aid of an objection as to why it makes a difference. At this point It's hard for me to tell.

Go ahead and proceed.

Counsel, we're going to take our break in about ten minutes.

MR. GREENE: Okay. We will make progress.

BY MR. GREENE:

Q. Mr. Crouch, why was this document created?

A. **So this is the primary tool we use in-house to compare payment allowances between hospitals. In Idaho there are 40-ish hospitals; 9 or 10 of them are what we would consider to be large hospitals. They are in the peer group that is shown unredacted. And it is the method we use to make sure that -- well, I guess there are two things: This supports two policy positions or supporting material for two policies. One is we have a written policy that it is our intent to reimburse cost-efficient providers at a market-appropriate profit so that we don't incentivize inefficiency.**

And a second policy is that we want to, for almost every procedure that we can imagine, have a negotiated payment allowance and not rely on a provider's billed charge to determine what the payment should be, a whole series of

other policies that this supports.

So in the early 2000s we created this document as a method to accomplish that. The methodology we follow is we take every hospital's claims that were billed to us, and we recalculate those claims on what Medicare would have paid them. The reason we use Medicare is because it's a standardized benchmark. And then we compare each hospital against one another, so you can see the -- we could have made a bigger version of this. This is a little small. So the last column that is not redacted shows the simple average for that hospital when compared to their peer group.

So this is what informs us during our contract negotiation cycle as to whether hospitals are becoming overly compensated and undercompensated.

THE COURT: So the vertical column, are those different treatments or care that is being provided?

THE WITNESS: No. So we separate -- if you'll look at the -- I'll point -- if you look at the first pair of columns that are unredacted --

THE COURT: They're showing -- what they've blown up here is the last column.

THE WITNESS: So the -- did you want me to talk about the last column?

THE COURT: If you can explain what the various columns are. I can't see it well enough when we look at all

of them. Can you go column by column? Can you explain that?

THE WITNESS: Sure.

THE COURT: Let's start with the first.

THE WITNESS: The first column is the hospital. So it shows the hospital's name, "St. Luke's Magic Valley Wood River." "BM" is Boise Meridian. You can see "Saint Alphonsus" is highlighted.

THE COURT: So what you have included would be the hospitals that you think would be relevant in the Treasure Valley?

THE WITNESS: Correct. Did you want me to describe why some of this material is redacted, why we believe that was necessary?

THE COURT: Well, I am assuming because you treat that somewhat as a trade secret, is this information given to those individuals or those companies that you are negotiating with?

THE WITNESS: No, we don't disclose it.

THE COURT: It's just an internal document.

THE WITNESS: Internal only. Our concern is that if it were -- let's say we're published as part of the court record and all the hospitals on the bottom end of it would say, "I need a payment increase."

BY MR. GREENE:

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Q. In looking at St. Luke's Boise-Meridian, can you compare -- can you compare where they were, say, in the first period versus the last period?

A. The first set of columns there are their out -- "OP" is outpatient. So this sheet is not measuring from one period of time to another period of time. This is saying for outpatient services, St. Luke's Magic Valley is 7 percent above their peer group; for inpatient services Magic Valley is 40 percent above their peer group. When you do a weighted average of those two numbers, they are 121 percent above their peer group.

Q. In absolute terms how do they compare with the rest of their peer group?

A. When I am using this I would look at the last column, and that would show that they are 21 points above average in their peer group.

Q. How about St. Luke's Boise, Meridian?

A. There again, I jumped to the last column. They're 17 percentage points above their peer group. And if I wanted to identify the drivers, we would look at outpatient and inpatient separately.

This is an example of why we provided that outpatient data. It shows that even though relative to their peer groups they are a little bit under, overall, their peer group, they are still dramatically higher when

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compared to the open market for those commodity services.

THE COURT: I'm not sure I see the commodity services. If I am reading this correctly, the first column identifies the hospital, the second column is outpatient?

THE WITNESS: Yes.

THE COURT: The third column is inpatient?

THE WITNESS: Yes.

THE COURT: And the fourth column is an average of the first two?

THE WITNESS: Yes.

THE COURT: Where is the commodity pricing? That's not reflected here?

THE WITNESS: No, that's not. That would go back to the other slide.

THE COURT: That's what threw me. All right.

BY MR. GREENE:

Q. Now, if you would look at the -- what I think of as the first page of this, at the bottom of the last page on your stack -- and I'll ask Clinton to bring that up.

So what I'm going to ask you to do is to --

THE COURT: Counsel, let me back up and ask a question or two to make sure I understand.

Now, in arriving at these numbers, the methodology was to take the average of all inpatient and outpatient charges --

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THE WITNESS: No, we take the --

THE COURT: Or reimbursement rates?

THE WITNESS: Yes.

THE COURT: Reimbursement rates.

THE WITNESS: Right. And it's not the average; we recalculate the reimbursement for every claim and recalculate it on Medicare --

THE COURT: So it is weighted in the sense that it actually shows what was being charged so that if you have a lot of one particular procedure, it's going to be appropriately weighted and included more often because it occurs more frequently?

THE WITNESS: Correct.

THE COURT: And that simply was taken from the reimbursement history for these facilities. Is that an annual?

THE WITNESS: Produce it annually.

THE COURT: And this was for what year?

THE WITNESS: This was for 2012, so it would be a running 12 months, not a calendar 12 months.

THE COURT: All right.

Mr. Greene, go ahead. You have only three minutes. And I apologize for wasting your time.

BY MR. GREENE:

Q. Mr. Crouch, has the relative position of the

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St. Luke's hospitals changed over time, in terms of how they compare to other hospitals in Idaho?

A. In 2007, the Boise facility was an average paid facility in the state, and they had one facility in the top five in Idaho. The range in 2007 is the highest compensated hospital was 9 percentage points above the average. In 2012, St. Luke's were the top three hospitals in Idaho, and the range for the top hospital was 21 percent higher than for the average hospital.

Q. What explains that increase over that period of time?

A. It is purely market negotiations.

THE COURT: So what is now up on the screen is for the year 2007; is that correct?

THE WITNESS: The title is not showing on there. Is that the last --

THE COURT: The numbers you gave correspond to, roughly, what is shown on the chart, I think.

Counsel, can you tell?

THE WITNESS: Yes, I think that's correct. That might be 2008. It looks like it's the January through December 2009 even, so there would be earlier periods that would show.

THE COURT: There was an earlier period?

THE WITNESS: Yes.

THE COURT: All right. Thank you.

MR. GREENE: Maybe move on to another document, Your Honor. It may be a good moment to take our break.

THE COURT: We'll probably just take a break if this is a good breaking point. Mr. Stein, if you have questions in aid of an objection, you might want to use your time afterwards or when we come back, if you want to object at this time, or you can cover it on cross and move to strike.

Although, actually, none of the exhibits have been offered. I assume, Mr. Greene, when you conclude with Mr. Crouch you're going to actually offer these exhibits.

MR. GREENE: Yes. I thought in conversation with Mr. Metcalf that offering at the end of direct made the most sense conceptually.

THE COURT: That's fine.

If there is going to be -- I think, Mr. Stein, if there's going to be an objection in which you are going to perhaps want to inquire of the witness, I think it might be good to take it up while it's fresh in my mind rather than try to wait until the end. My mind will then have to reengage and that could take a while.

I think what we might do then is if you want to inquire in aid of objections, Mr. Stein, you can do so after we come back from the 15-minute break. Otherwise, we'll wait until

the end of the direct examination, Mr. Greene will offer the exhibits, and those will be admitted without objection, but we'll see.

We'll be in recess for 15 minutes.

(Whereupon, recess taken.)

THE COURT: I will note for the record that the witness has retaken the stand. Mr. Crouch, I'll remind you that you are still under oath.

Mr. Stein, did you want to examine now and waive an objection or just go?

MR. STEIN: Whatever Your Honor would prefer. I can do it during my cross-examination or --

THE COURT: That might be as well. I may reserve ruling on the admission of that exhibit until after you have done your cross, which might be a little more efficient.

With that, Mr. Greene.

MR. GREENE: Thank you, Your Honor.

BY MR. GREENE:

Q. Mr. Crouch, I think one of your last answers to me was that you thought these increased charges at these hospitals reflected the exercise of market power or words to that effect. Can you remind me what your testimony was?

A. Our increased payment allowances. This isn't measuring their charges. What is shown here is the payment allowances. These are a result of their market position,

yes.

Q. Does that, in your mind, have -- is that caused by their acquisition strategy in their acquisition of additional practice groups?

A. It's a combination of practices and hospitals. So by this point I think we are on the 2012 slide. St. Luke's had become the sole supplier or the dominant supplier of hospital and professional services in five markets. And since that date it has expanded to two additional markets. But it was that market position in those markets that led to the increases.

Q. Thank you. Let me take the next exhibit in order.

THE COURT: Can I ask a question while you're bringing that up. This chart, this Conversion Factor Chart, was prepared by Blue Cross of Idaho and has been prepared annually for seven or eight years at least.

THE WITNESS: More than that, a decade at least.

THE COURT: It is something you do routinely and it is drawn from your other records and the compilation is created in anticipation of negotiation with all of the various healthcare providers that are listed there?

THE WITNESS: Correct. It is produced annually. It is distributed internally to senior executives annually who then begin conversations about our budget cycles and other elements.

THE COURT: Obviously, you're dependent upon the accuracy of those reports to ensure that you have accurate information as you enter into these negotiations; correct?

THE WITNESS: Yes.

THE COURT: It was not prepared for this litigation at all.

THE WITNESS: No, not at all.

THE COURT: No tweaking or changing of the data; this is exactly the report you looked at in 2007 or 2008 and then again in 2012 in the two versions we saw on the screen?

THE WITNESS: That is correct.

THE COURT: Proceed, Mr. Greene.

MR. GREENE: Thank you very much, Your Honor.

BY MR. GREENE:

Q. Turning your attention, Mr. Crouch, to what has been marked as Plaintiffs' Exhibit 1301. What is that document?

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REDACTED

MR. STEIN: Your Honor, I move to strike the answer as nonresponsive. We are getting again into Medicare Advantage, and I thought the Court had indicated it was outside the scope.

THE COURT: Counsel, I do think we need to --

MR. STEIN: Your Honor, I think this is speaking to the private plaintiffs' case.

MR. GREENE: If I may be heard on this, Your Honor.

There are two levels of this, if I may speak to it. The Medicare Advantage is a federal program at some level. However, the precise internal pieces of it, the financial pieces, are negotiated between, in this instance, Blue Cross of Idaho and St. Luke's. The next question will focus on the sharing of costs and benefits associated with that. And if I may proffer to the Court, it is likely that this witness will say that they were essentially squeezed down substantially and that that squeeze down came from the enhanced market power of St. Luke's Health System.

THE COURT: Mr. Stein, the reason I hesitate is I think what Mr. Greene is now pointing out, my sense is that it is somewhat like supplemental insurance, there is a negotiated component to the Medicare Advantage program, and I was just kind of assuming that. If that indeed is the

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case, then I will overrule the objection. But if rather than that there is not a negotiated rate, it is simply a federal regulation and a rate prescribed either by rule or regulation, I will sustain the objection.

MR. STEIN: Your Honor's understanding is correct. But my point was: This is a case about a commercial market. Mr. Crouch has testified and plaintiffs' representatives testified that Medicare Advantage is not a commercial product; it is distinct from a commercial product. If we look at the plaintiffs' complaints, it is focused on commercial products.

THE COURT: Mr. Ettinger, I'm going to overrule the objection. So we'll save you a little energy there.

The objection is overruled. Proceed.

MR. ETTINGER: Thank you, You Honor.

BY MR. GREENE:

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REDACTED

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REDACTED

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REDACTED

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REDACTED

Q. Let me turn back to the Nampa area and Saltzer. So does Blue Cross of Idaho require primary care physicians in the Nampa area to serve local residents?

A. We don't have a requirement they would serve any particular resident.

Q. But in order to sell a viable network, do you need primary care physicians in Nampa to serve patients in Nampa?

A. Yes. There is a high correlation between membership we have in a community and whether the primary care providers in that community are under contract.

Q. Do you regard Nampa as its own separate community?

A. Yes.

Q. From your perspective, is this a separate market?

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A. Yes.
Q. Based on that, what do you think the likely long-term effects of the St. Luke's-Saltzer transaction might be?
A. Our concern is that it would follow the same pattern we observed in Magic Valley and other markets where St. Luke's had, instead of being the dominant provider of hospital and physician services in five markets, at this point it is seven markets, it would add that other market.
Q. Do you understand that some of BCI's Nampa members travel to Boise for PCP services?
A. Yes, we see that in the data.
Q. And does that indicate to you that you could serve the Nampa market with Boise-based physicians?
A. Our understanding of where members receive their primary care services is that they either receive it where they live or where they work. When you look at family members who do not work or dependents, they are going to receive their care in the community in which they reside. Sometimes the working spouse will decide to pick the primary care provider close to their work because he can avoid the commute in that case. That would explain, I think, most of the difference.
Q. Could BCI, in your judgment, offer a network with other primary care physician groups in Nampa but not

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St. Luke's-Saltzer that would be attractive to Nampa area employers?
A. Saltzer has 50-ish primary care providers. They are easily the largest primary care provider in Nampa. In fact, they are the largest non-hospital-based clinic in the state of Idaho. So we would be very challenged to -- we would not expect people would go pick another provider; they would stay with their Saltzer provider.
Q. Could you provide a commercially viable network with only non-St. Luke's, non-Saltzer primary care physicians for Nampa area employers?
MR. STEIN: Object to lack of foundation.
THE COURT: I'm sorry?
MR. STEIN: Lack of foundation.
THE COURT: Overruled.
THE WITNESS: We do not have a lot of experience in Idaho at Blue Cross of Idaho in having physicians go noncontracting and see what the results will be. The one level of experience we have is with the Magic Valley where the docs in Magic Valley were not contracting. We saw even with 65 percent of the physicians in the marketplace under contract, having those 35 percent that were the primary care doctors leave the network meant we did not sell products in that market.
BY MR. GREENE:

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Q. Apropos of that point, if a plan without St. Luke's/Saltzer would not be marketable to local employers in Nampa, what kind of impact would that have on BCI's ability to negotiate with St. Luke's/Saltzer?
A. Are you saying -- could you repeat the question.
Q. Sure.
If a plan without St. Luke's/Saltzer would not be marketable to local employers in Nampa, what impact would that have on BCI's ability to negotiate with St. Luke's/Saltzer?
A. Now, are you assuming that in that case Saltzer is with St. Luke's?
Q. Yes.
A. It weakens our ability to negotiate with St. Luke's.
Q. Would that result in higher prices or higher reimbursement rates, from your perspective?
MR. STEIN: Objection, speculation.
THE COURT: Overruled.
THE WITNESS: Our PPO product is the most competitively priced product in almost every market. If you go back to when I first came to the health plan in 2001, end of 2001, Regence Blue Shield of Idaho and Blue Cross of Idaho were essentially the same size. We had the same number of members, something on the order of 200,000

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members. Between 2001 and 2013, Regence had dropped to 120, 150, I don't recall the exact number of members. Blue Cross of Idaho has grown to over 400,000 members. That is entirely the result of premium improvements we have made in the marketplace. Every year we attempt to improve our relative position by half a point or a point.
And that relative position has improved through utilization management, through intelligent benefit design, through collaborations with providers in attempt to control costs, and through management of our provider payment fee schedules.
If we are not able to sell in any particular community, the next choice the members of that community have are going to be higher insurance costs.
BY MR. GREENE:
Q. Would those higher costs be passed on to local employers and employees?
A. Yes.
Q. So could BCI defeat the market power of St. Luke's/Saltzer using a directed product?
MR. STEIN: Object to the form, Your Honor, just the "market power."
THE COURT: I am more concerned about "directed product."
MR. GREENE: Let me back up.

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THE COURT: And rephrase on both counts.
BY MR. GREENE:
Q. Mr. Crouch, what is a directed product?
A. A directed product is an insurance product which is composed of a narrow network of providers. And that narrow network of providers we have in the marketplace right now is with the Saint Al's system. It's called our ConnectedCare product.
Q. Does that provide either incentives or disincentives to people to use the preferred provider?
A. The benefit design is such if a member goes to a nonpreferred provider, noncontracting provider in that case, the member is exposed to the full bill charges of the noncontracting provider.
Q. So that creates both an incentive and a disincentive?
A. It creates both, yes.
Q. How successful has ConnectedCare been?
A. We sold just over 220 members on that product in a little over a year.
Q. That seems like a very small number. Is it from the perspective of someone in your business?
A. Yes, that is a small number.
Q. To what do you attribute the small number of sales with respect to this product?

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A. St. Luke's is not in the network. If you live in the Treasure Valley and this is a product for commercial age members, so non-retirees, if you wanted network in the Treasure Valley, you want St. Luke's to be in the network because they have all of the pediatric specialties, they have almost all of the OB/GYN docs in the region, they have the largest number of primary care and specialty physicians.
Q. Focusing just on the Nampa area, if you did not have St. Luke's/Saltzer available to you, could you construct something like ConnectedCare that would successfully shift patients to the remaining primary care physicians?
A. That is what we have, in fact, but people aren't buying that product.
Q. What is the current discount or percentage difference?

REDACTED

Q. If you increase that, do you think you could successfully shift patients from St. Luke's/Saltzer to other providers?
A. We went into that product assuming that with a

REDACTED

the market; we'd have some attraction to the market. That, in fact, did not happen. So we are now thinking a pricing

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REDACTED

Q. Are you aware, other than your ConnectedCare product, are there any other directed products in the Idaho market that have been successful?
A. In north Idaho there have been directed products that go to the North Idaho Health Network. They have had success over the years. Although I would say that managed care policies fell out of favor across the country in the '90s and 2000s. It is only recently they are starting to come back because there is a recognition that premium levels are so high that is an obvious method to attempt to bring premium levels down.
Q. And to your knowledge, have there been any successful programs other than the one you just identified in Idaho?
A. No.
Q. You have mentioned SelectHealth a couple of times during your testimony today. What is SelectHealth?
A. SelectHealth is an insurance carrier out of Utah.
Q. And to the extent you know, do they have some sort of business relationship with St. Luke's?
A. Yes. To our knowledge, St. Luke's brought them into the marketplace to be -- essentially to use the St. Luke's insurance license or the SelectHealth insurance

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license for St. Luke's to then develop a directed product into the St. Luke's system.
Q. Do you regard them as competitors or competitive?
A. Yes.
Q. Do you perceive them as a significant competitive threat to Blue Cross of Idaho?
A. They don't have a lot of membership currently, but they are affiliated with Intermountain Healthcare in Utah, which is a very formidable plan in Utah. So yes, they would be a future threat.
Q. Are you familiar with the BrightPath network?
A. Yes.
Q. What is that?
A. It's a network that St. Luke's has managed over time composed of St. Luke's employed physicians and independent physicians in the community.
Q. And what is the connection between that network and the SelectHealth product?
A. I believe the SelectHealth product is based on the BrightPath network.
Q. Do you know whether Saltzer is in the BrightPath network?
A. Yes, they are.
Q. If St. Luke's does not acquire Saltzer, would SelectHealth still be able to market a product, including

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Saltzer?
MR. STEIN: Object to lack of foundation. I believe he's asking the witness to testify about whether another different insurance company, how they could market.
THE COURT: The witness clearly understands negotiating -- not only understands, but has experience with Blue Cross in terms of its negotiations, both with employers and with healthcare providers. But in terms of being able to market a product, whether another entity could enter into the market, I'm not sure his knowledge goes that far. Perhaps it does. Perhaps we'll lay a little more foundation not only in terms of Blue Cross's involvement in the market, but also generally whether his background allows him to -- and perhaps that is part of his assignment at Blue Cross of Idaho is also to anticipate possible competition in the market which may be sufficient.
But at this point, I think we need further foundation.
MR. GREENE: Yes. Actually, let me do this with a hypothetical, Your Honor. That point is very well taken.
BY MR. GREENE:
Q. Hypothetically speaking, Mr. Crouch, if SelectHealth had Saltzer and Blue Cross of Idaho did not have Saltzer in their respective networks, would that give an advantage to St. Luke's?
A. Yes, that is our understanding of one of the major

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drivers for acquiring the Saltzer practice.
Q. What would be the nature of that advantage?
MR. STEIN: Your Honor, I'm just going to object to that answer for lack of foundation.
MR. GREENE: It was a hypothetical.
MR. STEIN: Not the answer, it was about his understanding.
THE COURT: I am going to overrule the objection. You may answer.
THE WITNESS: In Nampa part of the acquisition Saltzer participated with both the BrightPath network, which is the SelectHealth product, and with the ConnectedCare network, which is the Blue Cross of Idaho product. So in that respect, Nampa was a competitive marketplace because you could obtain either of those insurance products and still maintain your relationship with your Saltzer physician.
BY MR. GREENE:
Q. And just to be clear, Saltzer was in the BrightPath network before the acquisition, correct?
A. I believe it had been in the BrightPath network since its inception.
MR. GREENE: Mr. Crouch, thank you for your attention. I pass the witness.
THE COURT: Just so I am clear. Do the private

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plaintiffs intend to examine? I don't know if there was an understanding among counsel.
MR. GREENE: I need to bring in the evidence, Your Honor.
THE COURT: I'm sorry?
MR. GREENE: I do need to move the evidence into the record.
THE COURT: Maybe you can respond to my question here in a moment.
I have Exhibits 1296 through 1302. You are moving to admit all those exhibits?
MR. GREENE: Yes, Your Honor. We are proposing to move into evidence, let me just tick them off, the ones we used: Exhibit 1296 has been stipulated to; 1297 there are relevance objections, which is the standing objection from Mr. Stein; 1298, similar, 402, 403 objections, also foundation, which I believe I have now laid; 1299, again, principally a 403 objection; 1300, 403, foundation, we have covered that; 1301 has been stipulated to; 1302 also has a relevance objection. And I don't believe there are significant objections to the demonstratives, at least the map of Magic Valley there has been no objection that I am aware of, and Your Honor has already struck the Medicare payment policy demonstrative.
THE COURT: Mr. Stein, Counsel, I think probably

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the most profitable way to go through this is I will identify which exhibits have been -- well, Counsel can indicate which exhibits are being offered. I have your exhibit list, so I know what the objections were. However, sometimes those objections go away once they are actually presented through a live witness.
So Mr. Stein, as you indicate, I'm assuming you stipulate to 1296 and 1301?
MR. STEIN: That's correct, Your Honor.
THE COURT: Are you maintaining the same objections noted in the exhibit list?
MR. STEIN: That's correct, Your Honor.
THE COURT: I am going to admit Exhibits 1296, 1297, 1298, 1299, I'll reserve ruling on 1300 until Counsel has had a chance to inquire during cross in aid of any objection they may have. I'll admit Exhibits 1301 and 1302, overruling any objections to those exhibits.
(Whereupon, Plaintiff's Exhibit Nos. 1296, 1297, 1298, 1299, 1301, and 1302 were admitted into evidence.)
THE COURT: Now, Mr. Greene, anything else?
MR. GREENE: Well, just a question of sort of appropriate process here. I believe my colleague Mr. Stein does not recollect that his objections to the BCI exhibit that Your Honor is holding back, 1300, was actually the

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subject of a motion to compel, which was actually decided against St. Luke's by Judge Bush. So I'm sure this is just a matter of not recalling that.

But this may be law of the case or something potentially, but there is, it is the case that there was argument on this, this was before Judge Bush, and to my knowledge it was not appealed to Your Honor in a timely way. My sense of this is it is done.

THE COURT: I don't know the motion to compel or objection at that level would necessarily preclude counsel from raising it during trial. I don't know what exactly Judge Bush decided, but of course the issues here may be somewhat different.

The standard for relevance, for example, is much broader in a discovery dispute than it would be at trial. If there were other objections where Judge Bush has ruled and somehow it does become law of the case, then I am certainly going to hear argument. But I have generally not regarded the resolution of an issue during a discovery dispute to either bind counsel or the Court from readdressing the subject during trial.

MR. GREENE: I have only quickly reread Judge Bush's analysis and opinion. I believe this is document No. 130, so Your Honor can certainly take a look at it, and starting at page 10 there is a discussion of the BCI -- I'm

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sorry, the St. Luke's perspective on this. They suggested, as Mr. Stein did before the Court earlier today, that there was an unfairness in them not being able to see the parts that were redacted. So this goes primarily to a redaction set of issues.

My understanding is that Judge Bush was quite clear that is not inappropriate. The redactions were perfectly proper in that context. And it is the case, I understand, that Mr. Stein was shown the underlying -- well, two things: Mr. Stein was shown the full document in his office that was taken over to him by a representative of Blue Cross of Idaho. So he got to see them in Sidley's offices in Chicago, spent time with them, reviewed them. And the underlying data on which these things were built was actually produced to St. Luke's over time.

So on the relevance point, we can certainly more fully debate that, but at least in terms of any alleged improprieties associated with this, that has not been decided.

THE COURT: Now, Mr. Ettinger or Mr. Powers, do either of you intend or is there an understanding that you will forgo any direct examination of Mr. Crouch or any other witness? I am just trying to get clear kind of the understanding of counsel. You have independent issues; you are not joined at the hip with government plaintiffs,

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probably at the elbow, but not the hip.

So I need to know how will you indicate if you intend to ask any additional questions beyond those asked by the government attorneys. And I suppose it may go the other way when there are witnesses that are being called by the private plaintiffs.

MR. ETTINGER: Your Honor, I have no questions of Mr. Crouch at this time.

I think generally the plaintiffs are endeavoring to have one questioner for all the plaintiffs per witness. Without any particular case, it is conceivable some counsel for some Plaintiff may want to ask a few of his own questions. We are trying not to make it a hard and fast rule, but that is our goal.

THE COURT: I will follow that. That will also inform my decision on the relevance rulings since I did allow counsel, Mr. Greene, to have leeway then to cover topics that would only be relevant as to the private plaintiffs as well and vice versa.

MR. GREENE: Thank you very much, Your Honor.

THE COURT: Mr. Stein.

MR. STEIN: Thank you, Your Honor.

I need the binder. See how frequently we have to reference it? I would like to have it available to the witness.

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THE COURT: Mr. Metcalf, do you want to provide that to the witness?

MR. METCALF: Yes.

MR. STEIN: Just for reference if we need it.

THE COURT: Yes.

CROSS-EXAMINATION

QUESTIONS BY MR. STEIN:

Q. Mr. Crouch, every provider and payor has market power, correct?

A. Certainly to some degree.

Q. So Saint Al's has market power, too?

A. Sure, some degree.

Q. In fact, you consider Saint Al's to be a must-have provider in Nampa because they have the only hospital in Nampa; right?

A. We consider Saint Al's the hospital entity to be a must-have provider.

Q. Right. So Nampa would be an example, wouldn't it, of the monopoly markets where you only have one hospital; right?

A. Right.

Q. Boise, of course, has two hospitals, two large hospitals competing against each other, Saint Al's and St. Luke's?

A. There's a third hospital in Boise, it's the

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Treasure Valley Hospital.
Q. And you testified earlier Blue Cross is the largest commercial insurer in the state of Idaho?
A. Yes.
Q. You have the most covered lives?
A. Yes.
Q. You have the largest reserves?
A. I don't know if we have the largest reserves. That may be true.
Q. And Blue Cross has market power, correct?
A. I believe every payor and every provider has some level of market power.
Q. So Blue Cross has market power?
A. Yes.
Q. In fact, Blue Cross dominates the large group market in Idaho; is that correct?
A. We have the most large group -- have the largest volume of large group business in Idaho.
Q. You dominate the large group market in Idaho?
A. How would you define "dominate"?
MR. STEIN: Can we put up Trial Exhibit 2145.
BY MR. STEIN:
Q. Mr. Crouch, do you recognize this to be the business plan and budget for the years 2012 to 2014 for Blue Cross of Idaho?

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A. Yes.

REDACTED

Q. One reason that Blue Cross dominates the large group market in Idaho is its favorable provider contracts; right?
A. True.
Q. Blue Cross is also the dominant insurer in self-funded accounts, employer accounts?
A. Isn't that what we just referenced?
Q. Is that correct?
A. Correct.
Q. In fact, Blue Cross maintains a dominant market share in all core product lines; correct?
A. We do not have dominant position for the SNP plan, which is a Medicare/Medicaid program. We once had a dominant position for Medicare Advantage, and that position was eroded this last January when premium levels were reduced by our competition.
Q. Competition, including SelectHealth?
A. Yes. But in that case it was PacificSource.
Q. One reason that Blue Cross is concerned about

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St. Luke's acquisition is that acquisition of physician practices opens opportunities for providers to become significant competitors of Blue Cross; right?
A. Our concern with physicians being acquired by providers is not that those physicians will become competitors of Blue Cross, but it eliminates competition in their market for physician services.
MR. STEIN: Let's put up Trial Exhibit 2632.
BY MR. STEIN:
Q. This is a document that was produced by Blue Cross titled "Risk Universe Definitions" discussing a number of risks. And you will see there at the top it says Competitor. Do you see that, Mr. Crouch?
A. Yes.
MR. STEIN: And George, can we cull out the bottom paragraph there.
BY MR. STEIN:
Q. The last sentence of this paragraph, which is a document that was produced by Blue Cross, says, quote: "Hospital consolidation and acquisition of physician practices opens opportunities for providers to become significant competitors"; correct?
A. That is a reference to St. Luke's and its health plan activities, not to providers becoming --
Q. Did I read that document correctly, Mr. Crouch?

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A. I believe you interpreted it incorrectly.
Q. In fact, St. Luke's is affiliated with SelectHealth, the insurance company that is competing with Blue Cross in this market now; is that right?
A. That's correct.
Q. And competition from SelectHealth in the market for commercial insurance has already forced Blue Cross to cut premiums to retain business; isn't that right?
A. I would not say that.
Q. You would dispute that?
A. I'm not saying I dispute it or agree with it, but I'm not familiar with what you are talking about.
Q. In fact, in negotiations between St. Luke's and Blue Cross over the current contract, the CEO, now CEO of Blue Cross, Ms. Geyer-Sylvia, told Randy Billings of St. Luke's that St. Luke's affiliation with SelectHealth was going to make reaching an agreement with Blue Cross more difficult; isn't that right?
A. Correct.
Q. And Blue Cross is concerned that the rates it pays St. Luke's as a provider might help SelectHealth compete more effectively against Blue Cross in the insurance market; isn't that right?
A. Our concern in that respect is that St. Luke's is offering preferential rates to essentially what is its own

insurance company and requiring high rates to Blue Cross and other payors in the market so they can drive ownership to SelectHealth.

MR. STEIN: So let's put up Trial Exhibit 2589. George, can we just cull out the top part, the memorandum, to the first line.

BY MR. STEIN:

Q. Mr. Crouch, this is a memo to the Independent Public Directors Committee of Blue Cross dated August 30, 2012, from Ms. Geyer-Sylvia. Ms. Geyer-Sylvia is your boss; is that correct?

A. Yes, that's correct.

Q. The memo is regarding SelectHealth-St. Luke's Health System issue. Do you see that?

A. As the title, yes.

Q. Have you seen this memo before?

A. I saw it just recently, yes.

Q. What is the Independent Public Directors Committee?

A. It's our board of directors.

Q. So in the first paragraph of this memorandum Ms. Geyer-Sylvia states: "I wanted to alert the Independent Public Directors about a development in the market stemming from a recent discussion held with Dr. David Pate. When I spoke to David, he indicated that his staff would be

contacting us next week to alert us about a press release that St. Luke's planned to release on September 5, 2012. He stated that St. Luke's has entered into a strategic alliance with SelectHealth, an insurance company owned by Intermountain Healthcare in Salt Lake City, Utah."

Then in the next paragraph, Ms. Geyer-Sylvia continues: "David went on to state that this new alliance plans to offer insurance products in Idaho that would 'turn the payor/provider relationship on its head.'"

And Ms. Geyer-Sylvia continues in the next paragraph, in the middle of the paragraph she states: "The commercial individual product will compete directly with our Saint Alphonsus ConnectedCare product." Is that accurate?

A. The competition -- David Pate's statements we wouldn't agree with, but the competition statement is accurate.

Q. On page 2, Ms. Geyer-Sylvia goes on to say, the fourth line down: "As you know, we are currently in the midst of contract negotiations with St. Luke's for our rates of reimbursement for the next two years and we need to be concerned that agreeing to higher provider rates would essentially subsidize these new products and could adversely impact BCI's competing products." That is referring to the most recent contract negotiations; is that right?

A. Yes. That would be the negotiations for the 2013

contract.

Q. Mr. Crouch, you are not, you have not personally had any discussions with any employers about Saltzer Medical Group; is that right?

A. Not in my recent memory.

Q. You consider Saltzer to be a must-have provider for Blue Cross in Nampa; is that right?

A. Yes.

Q. You felt that way about Saltzer for years?

A. Yes.

Q. And yet despite the fact that Blue Cross views Saltzer as a must-have provider, Blue Cross has successfully resisted all attempts by Saltzer to negotiate physician fee amounts above the statewide fee schedule; isn't that right?

A. We don't negotiate physician fees specifically with individual providers. They are a member of our steering committee, so in that respect they influence our fees.

Q. Right. But they get the same statewide fees as every other provider in the state of Idaho; right?

A. If they're able to convince us to a different position, then every other provider will get that same increase which Saltzer receives.

Q. Mr. Crouch, Saltzer Medical Group receives the same physician fee schedule amount as every other physician

on the statewide fee schedule; correct?

A. That is correct.

Q. And despite their attempts to negotiate reimbursement higher than the statewide fee schedule, they have been unable to do that; is that right?

A. Let me see if I understand your question correctly. Are you asking if we would negotiate with Saltzer only and violate the any-willing-provider law and not allow those payments to go to other providers?

Q. Well, it's interesting you mention that, Mr. Crouch. Do you have a law degree?

A. No.

Q. So you are not offering a legal interpretation of the any-willing-provider law, are you?

A. I'm offering my understanding. I am the person at Blue Cross of Idaho that has to live within the constraints of that law.

Q. What you are saying then is Blue Cross does not have and has never had an agreement with any provider to pay more than the statewide fee schedule?

A. No, I'm not saying that. We spoke about exceptions to that earlier today.

Q. Right. One group that has never been able to negotiate an exception is Saltzer Medical Group; correct?

A. We have made compromises, breach compromises with

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Saltzer around language in our contracts and anything that they could convince us of in addition to our fee schedules were then implemented for our entire fee schedule.

Q. Mr. Crouch, I'm going to keep asking this question, and please answer it directly: Saltzer Medical Group has never been able to negotiate an increase for themselves above the statewide fee schedule?

A. That is correct, yes.

Q. Now, you have done no study of what distinguishes those Nampa members who leave Nampa for primary care from those who don't; correct?

A. I have not done that study.

Q. You don't know how many more members would travel outside Nampa for primary care if Saltzer and St. Luke's were not in the Blue Cross network; is that right?

A. I would be left to my experience in other markets to make that judgment.

Q. You don't know how many members would switch to Saint Al's or Primary Health providers in Nampa if Saltzer and St. Luke's weren't in the Blue Cross network; correct?

A. Have we literally counted the number of members and attributed them to new providers?

Q. No. My question is simpler than that. You don't know how many members in Nampa would switch to Saint Al's or Primary Health as opposed to staying with out-of-network

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Saltzer and St. Luke's if Saltzer and St. Luke's weren't in the network?

A. So you are saying if St. Luke's leaves the network and Saltzer leaves with them, how many would stay and how many would go?

Q. Right.

A. No, we have not calculated that number.

Q. If Saltzer and St. Luke's were not in the Blue Cross network, Blue Cross members would still have access to primary care providers in Nampa, in their community; right?

A. As we look at the data we look at the volume of services rendered within Saltzer and they are 80 percent of the primary care services for Medicare Advantage and 60-something percentage of the services for commercial.

Q. And if they were not in the network and St. Luke's were not in the network, Blue Cross members would still have access to Saint Al's primary care providers, Primary Health providers, and other independent providers in Nampa; correct?

A. Well, let me see if I can clarify for you. When members pick a primary care provider, they are not picking the insurance company they like and then going with that primary care provider. They are selecting the primary care provider they like and looking for an insurance policy that covers that provider.

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Q. Mr. Crouch, maybe my question wasn't clear, so I'll ask it again. If the Saltzer and St. Luke's physicians were no longer in the Blue Cross network, Blue Cross members in Nampa would still be able to see primary care physicians in their communities?

A. Yes, there would be a financial penalty for them to do that if they retained their care with Saltzer.

Q. But there would be no financial penalty for them to stay in network and see Saint Al's primary care providers or primary care providers related with Primary Health Medical Group; correct?

A. That is correct if they were willing to change their primary care provider.

Q. Now, I would like to go back for a second to one of the slides that you talked about in connection with this kickoff presentation that you talked about.

MR. STEIN: George, can we pull up Trial Exhibit 1299. The next page.

BY MR. STEIN:

Q. Now, Mr. Crouch, this is a presentation for this kickoff meeting. Would it be fair to say this was prepared to tell Blue Cross's side of the story going into the contract negotiations?

A. Yes, that is the purpose.

MR. STEIN: And can we go to slide 4.

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BY MR. STEIN:

Q. And this was one of the slides that you discussed, presented to St. Luke's and discussed with them; is that right?

A. Yes.

Q. And the purpose of this slide was to argue to St. Luke's that they were overcompensated compared to peers; is that right?

A. Well, we had multiple purposes for this slide. One was to show that regardless of what level of payment we are making to them, outpatient services are tending to be overpaid relative to inpatient services. And that has been a strategy of ours for many years. So we're reinforcing that position.

And then the second is that they are already, and as we have seen later data that shows their relative position has, in their opinion, improved, is that they are already highly compensated.

Q. Mr. Crouch, the information in this slide comes from those conversion factor reports, those heavily redacted documents we looked at earlier; is that right?

A. That is correct.

Q. And the information on this slide comes from the 2011 version of the conversion factor report?

A. Yes, that's correct.

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Q. And in the bottom asterisk there at the very bottom of the page it says: "Percentage of BCI based on all negotiated hospitals." What does that mean?

A. We calculate their -- I'm not recalling exactly what we used as the benchmark -- in this case it is referencing all negotiated hospitals, so I'll assume that the footnote is correct. It would compare them against all, every hospital where we have a negotiated payment amount.

Q. This was information on this slide that you thought was important to show to Blue Cross -- I'm sorry, to St. Luke's as part of the negotiations?

A. Yes, that is why we prepared this slide.

Q. And there is a column there titled "Percent of BCI in IP Average." Does that mean inpatient average; is that right?

A. Yes, that's correct.

Q. Am I correct that the data here, if we go back to the conversion factor report, this comes from the column in the conversion factor report that shows the weighted average percentage rather than that column for the simple percentage we saw in that document; is that right?

A. We would have to pull the document back up to be sure.

MR. STEIN: George, can we do that?

BY MR. STEIN:

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Q. So we are going to put Exhibit 1299 side by side with Exhibit 1300 for the 2011 report. So on the slide you showed to St. Luke's, you have got rankings of 113, 113, 96, 115, and 99. Do you see that?

A. On the slide we looked at earlier it was 2012. I'm sorry, I cannot read on the screen very well.

Q. Okay.

A. Okay. Could you repeat that again.

Q. Sure. I am just noting that in the presentation --

A. Oh, sure. Yes, I see the number you are looking at.

Q. Right. Do you see now the information that Blue Cross decided to pull that Blue Cross thought was important to show to St. Luke's came from the weighted average column, not a simple averaged column in the conversion factor report; is that right?

A. I think it was to their benefit to show that number. It would show as a greater outlier if they used the other number.

Q. The information that Blue Cross chose to show --

THE COURT: Just a moment. What was the weighting again? Was it what we discussed earlier?

THE WITNESS: No, there are two different weights that are used here. So in this case, when we are comparing

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the peer group like, so we are saying St. Luke's Magic Valley compared to the other hospitals.

THE COURT: Hospitals in the entire state in their contract?

THE WITNESS: In their peer group that have that negotiated. There are a bunch of hospitals. If they're critical access hospitals we don't really negotiate with them much.

So, in this case, we can calculate their percent of the simple average, which means that if there are ten hospitals, we don't take into account the size of the hospital. In this case, we are doing a weighted average.

THE COURT: So the weighted average takes into account the size of the hospital?

THE WITNESS: Well, I think more to the point, let me see if I am looking at this data correctly. A weighted average means that St. Luke's Boise, which is the largest hospital in the state by far, drives the average because they are so large.

THE COURT: But that is the point is that the weighted average does include the size of the hospital.

THE WITNESS: Yes.

THE COURT: Go ahead. Mr. Stein, I apologize, but when I have a question, I feel the need to ask it. So go ahead.

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MR. STEIN: We are here to educate you, Your Honor. No need to apologize.

THE COURT: You have a lot of work to do.

Go ahead.

BY MR. STEIN:

Q. Mr. Crouch, the information that Blue Cross shared with St. Luke's came from the weighted average column in the conversion factor report; is that right?

A. Yes.

MR. STEIN: So, George, we can pull that down.

BY MR. STEIN:

Q. Now let's go back to the most recent conversion factor report, the one from 2012 that you talked about with Mr. Greene. And let's pull up that last column, the one that considers both inpatient and outpatient. As you did with St. Luke's in the kickoff presentation last year, let's focus on the weighted average.

Now, according to the weighted average for the 2012 report, St. Luke's Magic Valley, Wood River, and Boise-Meridian were respectively 114 percent, 111 percent, and 109 percent; is that correct?

A. Yes.

Q. And now, the fourth and sixth hospitals on the list you can't see because they have been redacted, they are also at 109 percent; is that right?

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A. Yes.
Q. Those are not St. Luke's hospitals; correct?
A. Correct.
Q. But they negotiated the same reimbursement as St. Luke's Boise-Meridian?
A. The average, same average, yes.
Q. And the fifth hospital on that list, they are at the 112th percentile; is that right?
A. That's correct.
Q. That is also not a St. Luke's hospital?
A. Correct.
Q. And they negotiate -- yet they're at a percentile that's higher than both St. Luke's Boise-Meridian and Wood River; is that right?
A. On the weighted average statistic, that is correct.
Q. The purpose of these conversion factor reports is to compare hospitals to one another across the state; is that right?
A. So the column you are using here is a little different from what we were describing earlier. This is all hospitals. This includes those critical access hospitals, the highest paid hospitals in the state are always going to be critical access hospital because they're so small.
THE COURT: What is small? What is an example of

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critical access hospital? Like Harms Memorial in American Falls?
THE WITNESS: Yes.
THE COURT: Go ahead.
BY MR. STEIN:
Q. St. Luke's Wood River is also a critical access hospital; correct?
A. In Medicare's parlance, not in ours.
Q. Are you telling us today the hospitals whose names we cannot see that are fourth, fifth, and sixth, they are critical access hospitals?
A. No. On the top part of that chart, they would not be critical access.
Q. Right. But we cannot see who they are because that information has been blacked out; right?
A. I think you have seen who they are, but they're not disclosed on this chart.
Q. We cannot show it to the Court; correct?
A. I am not familiar with the Rules of Evidence for the Court.
Q. Can you tell us who they are?
A. They're redacted to me as well. I cannot see any names.
MR. STEIN: George, if we can just get rid of those cull outs.

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BY MR. STEIN:
Q. There is a lot of other columns of information, at least in this version of the document, that are redacted; right?
A. Yes.
Q. And at the bottom of the page in that small print there, is that describing the methodology that Blue Cross uses to generate these reports?
A. Yes, I believe it does.
Q. And there is a series of judgments that Blue Cross makes about certain claims to include and exclude?
A. Correct.
Q. And this is all run against a database that Blue Cross maintains claims statewide; is that right?
A. It comes out of our claims warehouse.
Q. Right.
And Blue Cross did not provide the parties in this case with all of the data statewide, did it?
A. I don't know what was provided for claims data.
Q. Without statewide data, the parties would have no way to test the different assumptions and the outcomes that might result if you changed those assumptions from this analysis; is that right?
A. I'm not sure it was provided in claims data. If you didn't have claims data, could you recreate this? You

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could not recreate this chart if you did not have the data.
Q. And we couldn't do the analysis underlying the chart; correct?
A. Without the claims data, that is correct.
Q. Now, would you agree that contract negotiations between Blue Cross and St. Luke's involved give and take by both sides?
A. With every negotiation there is give and take; that is true.
Q. In each of the negotiations Blue Cross gets some things, some things it wants, and St. Luke's get other things that it wants; is that fair?
A. Correct. Yes.
Q. The way the negotiations with Blue Cross and St. Luke's have worked historically is when you sit down, St. Luke's will typically propose a certain amount of rate increase, Blue Cross will propose a lower increase, and then over time the parties will reach agreement somewhere in the middle?
A. Between those two points, yes.
MR. STEIN: George, can we pull up Trial Exhibit 19.
BY MR. STEIN:
Q. I'm not going to ask you about this first page, but, Mr. Crouch, you recognize this document. It is called

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the contract rate signoff sheet?

A. I recognize it in a fuzzy way right now.

THE COURT: Counsel, what is this exhibit number?

MR. STEIN: It is Joint Exhibit 19.

THE COURT: Counsel, the Plaintiffs' exhibit, I assume those are deposition exhibit numbers?

MR. STEIN: Yes. The trial exhibit number is at the very bottom right-hand corner.

THE WITNESS: I have it here in front of me.

THE COURT: Counsel, again, I apologize. I am assuming that Exhibits 1 through 53 can be admitted since they have been designated as joint exhibits; is that correct?

MR. GREENE: That's correct. That is my understanding, Your Honor.

MR. STEIN: Yes.

THE COURT: Exhibits 1 through 53 will be admitted.

(Whereupon, Joint Exhibit Nos. 1 through 53 were admitted into evidence.)

THE COURT: Go ahead and proceed.

BY MR. STEIN:

REDACTED

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REDACTED

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REDACTED

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REDACTED

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REDACTED

THE COURT: Counsel, could I just -- this is 2634, I believe, you referred to it. The notation at the top is

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5070.

MR. STEIN: I'm sorry, Your Honor, that was an internal number.

THE COURT: So is this 2634?

MR. STEIN: It is 2634.

THE COURT: Thank you.

BY MR. STEIN:

Q. Now, Mr. Crouch, I want to show you a statement and get your reaction to it. Quote: "Hospitals need to fully cover their costs and to earn a reasonable margin in order to finance continuing investments in technology to keep improving patient care and also to keep up with healthcare cost inflation. Medicare and Medicaid do not reimburse hospitals for all their costs and do not provide this margin. In order to maintain a sufficient margin to fulfill their mission, hospitals need to obtain these revenues somewhere. Commercial insurers are the only potential source of revenues to make up for this governmental shortfall."

Does that sound like an argument you've heard from St. Luke's during your contract negotiations?

A. I think I drafted this in the early 2000s.

Q. This actually comes, we can show where this comes from, it comes from a document that Saint Alphonsus prepared just the end of last year to respond to some questions from

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the *Idaho Statesman*. But the argument that's being made there is one you have heard from St. Luke's; is that right?

A. I think we have heard it from internally as well. As I mentioned, it appeared like an argument I had been making.

Q. Am I correct that the dynamic that is referred there is something that is known as cost shifting?

A. Yes.

Q. And the idea behind cost shifting, the argument is that because the government doesn't pay providers enough on Medicare and Medicaid, that providers will seek to make up that difference from commercial payors since Medicare and Medicaid do not negotiate their rates. Is that the gist of the argument?

A. That is the gist of the argument. I think there is a different understanding in the industry now, but that was at one point the Kool-Aid.

THE COURT: Counsel, this is Exhibit 2235 for the record?

MR. STEIN: Yes. Thank you, Your Honor. 2235.

THE COURT: When we're referring to a document, I think we need to make sure we've identified the exhibit number so it's clear for the record.

BY MR. STEIN:

Q. I believe in your testimony when you were

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answering questions from Mr. Greene, you had referenced a couple of times a MedPAC report. What are MedPAC reports?

A. MedPAC is a consultant to Congress for issues related to the Medicare system.

Q. Do you consult the MedPAC report in the ordinary course of your business?

A. They publish reports twice a year and we I think just about every year will pull the reports down and go through the reports.

Q. This is not a document that is in evidence, but do you recognize this as the March 2012 MedPAC report?

A. Sure. I guess so.

Q. Is it one you would have reviewed? This is one of the biannual reports?

A. It is one of the -- I can't say I reviewed, I would have to look at the contents of the report to know if I have reviewed it.

MR. STEIN: Go to page 82.

BY MR. STEIN:

Q. Now, Table 3-4 of MedPAC report is titled "Overall Medicare Margins By Hospital Group." At the top there, am I correct this indicates that in every year that is reported here, the last year being 2010, the MedPAC is reporting that all hospitals on average are -- well, hospitals on average are losing money on Medicare business. Is that how you

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understand this chart?
A. The first line, is that what you are referring to?
Q. Yes.
A. Yes.
Q. About halfway down do you see there is a line for nonprofit?
A. Yes.
Q. For nonprofits like Saint Al's and St. Luke's, MedPAC is reporting the average margin on Medicare business in the most recent year for which there is a report is negative 5.7 percent; correct?
A. Correct.
Q. These are numbers nationwide?
A. I haven't read the footnotes, but I would suppose so.

REDACTED

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REDACTED

Mr. Ettinger.

MR. ETTINGER: Response to what you raised. Would it work for the Court if we at some point soon move the admission of all the joint and unobjected to exhibits and just got them out of the way?

THE COURT: I have already admitted all of the Joint Exhibits 1 through 53, I believe. As to anything that

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is not marked with an exhibit -- excuse me, an objection, apparently is stipulated to then; is that --

MR. STEIN: Your Honor, as a general matter, that is right. There has been some late exhibits exchanged by both sides, so I think we probably have to exchange some updated lists, but I think conceptually we are fine with that.

THE COURT: Why don't you at some point put together another exhibit list and designate stipulation or admission under the column for stipulation, and I will just refer to that and perhaps even docket that to indicate that those exhibits are all admitted without taking time here and my breath. For some reason, my voice seems to be getting weaker and weaker. Too many weeks of consecutive trial, I think.

Just to save that, I would prefer maybe just to admit them in that fashion, if counsel can put their heads together and do that.

Proceed.

We're going to take a break in about ten minutes, Mr. Stein, but I will let you kind of pick your breaking point in the cross-examination.

MR. STEIN: Thank you.

BY MR. STEIN:

Q. Mr. Crouch, we were talking a little bit before

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about the give and take that takes place between St. Luke's and Blue Cross. Am I correct that one of the points on which that give and take, which there has been discussion, is what has been referred to as provider-based billing?

A. Yes.

Q. And Blue Cross does not accept provider-based billing on the commercial side?

A. That is correct.

Q. That is a position you stuck to with success in negotiations with St. Luke's?

A. Yes.

Q. Primary care doctors are frequently the ones who are ordering the ancillary services like lab tests and imaging?

A. Correct.

Q. And Blue Cross members will typically pay the same amount for a physician visit, regardless of which in-network physician they receive; is that right?

A. With the PPO product, that is true.

Q. But even though members will pay the same for a physician visit for in-network providers, they may face price differences for services that are ordered by their primary care doctors like ancillary services; is that correct?

A. Yes. They would be subject to those price

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differences. It is not typically disclosed to them, though, when the referral is made.

Q. But in your experience, members will often become aware of the differences, the price implications of a physician's pattern of referral of services once the ancillary services are obtained?

A. There is a segment of the membership that would. We segment, like I think many organizations, we segment our clientele into different market segments. There is a portion of the market that is highly sensitive to pricing and that will research prices online, they will research diagnoses and whatnot. That is a -- this is sort of a foggy memory -- but that might represent 10 percent of our total membership. So that would be what I deemed the informed consumer, they have become aware of that difference over time.

Q. St. Luke's has cooperated with Blue Cross to help narrow the gap between hospitals and other providers for outpatient services; correct?

A. Are you referring to our outpatient fee schedules?

Q. I am referring to what you referred to as the difference between hospital reimbursement and community-based reimbursement for what you called commodity services.

A. The nuance here is they've not been willing to forgo payment; they demanded that payment in other parts of

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the contract.

So I gave you the case of a CT exam earlier. We might pay $600 on the open market for a CT exam, St. Luke's might have an $1,800 payment allowance. If we persuade them to a lower payment allowance, say, we persuade them down to $1,200, they are not forgoing that money; they are putting it in some other code.

Q. St. Luke's has been cooperative with Blue Cross in trying to reduce allowances for outpatient services; correct?

A. I guess I am sensitive to the way you phrase that because it represents that they have reduced allowances when in effect they've just redistributed amounts.

Q. St. Luke's has been working with Blue Cross to help narrow the gap between hospital reimbursement and ancillary services in community; correct?

A. Taken specific -- you couldn't make that specific statement, we'd need follow-up.

Q. Do you disagree with that statement?

A. No, I agree with that part of it.

Q. Blue Cross has also been taking steps in recent years to incentivize members to utilize lower cost providers of services; correct?

A. That's true of the industry in total and of Blue Cross.

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Q. You send communications to members through newsletters?

A. We do.

Q. You recently implemented a website that allows members to research online what the cost differentials are between providers for different kinds of services?

A. For a small set of services.

Q. Things like colonoscopies and knee arthroscopies?

A. Correct.

Q. Blue Cross also publishes online the out-of-pocket expenditures that members will pay for ancillary services for various items; is that right?

A. I'm not sure we have an online site where members can calculate out-of-pocket costs.

Q. Isn't it true that St. Luke's recently agreed to facilitate the disclosure of that type of information through modifying its contract?

A. That was not an agreement to facilitate disclosure. They agreed to different contract terms, but I think they have resisted any disclosure to the public.

Q. Didn't you testify, Mr. Crouch, is it your testimony that Blue Cross does not make that information available online?

A. So you've talked about several categories, one being price allowances, the other being out-of-pocket

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payment allowances. We do make price allowances available for about 500, might even be less than that.

Q. That is the out-of-pocket expenditures; correct?

A. No, price allowance. To calculate the out-of-pocket expenditure, you would need to know where the person is in meeting their deductible and what that person's benefit design would be, and we do not have that information available to them on the web.

MR. STEIN: Your Honor, I have going to move to a different topic that will take longer than when we break. I won't be done in a few minutes so if you would like to take a break now or I can just start.

THE COURT: We will take a break now. It is a few minutes early. That is fine. I think it is probably better not to break up the testimony if we can avoid it. Let's just go ahead and take a 15-minute recess.

We will be in recess for 15 minutes.

(Whereupon, recess taken.)

THE COURT: You have my apologies.

I will remind the witness you are still under oath.

Mr. Stein, you may resume your cross-examination. Counsel, was there a technical problem with the equipment? Is that why --

MR. STEIN: Yes, but I believe it is resolved.

THE COURT: All right. Very good. Proceed.

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BY MR. STEIN:

Q. Mr. Crouch, before we broke, I was asking you a question about reserves, and you indicated that you thought Blue Cross had something like 3 to 4 months' reserves. What are the monthly reserves?

A. You are asking a dollar amount?

Q. Yes.

A. I'm not sure of the dollar amount.

Q. Do you have a rough estimate?

A. I am recalling that conversation from our planning meeting about a year ago when we were talking about risk-based capital, capital adequacy as an example. Health plans have to have a risk-based capital equal to 200 percent or else they are considered technically insolvent and the state takes them over. So as we were talking internally, we were trying to identify are our reserve levels too high, and one of the statistics that came out was -- not necessarily a calculation I performed. If you divide all of our member reserves by our monthly claims expense, the total value of our reserves is between 90 and 120 days of claims expense.

Q. And do you have a dollar figure that you can put on that?

A. I don't. Not off the top of my head.

Q. In your testimony this morning you made reference several times to I think seven markets. Does that sound

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familiar?

A. Five markets that they've been dominant and now seven.

Q. Who is they?

A. St. Luke's.

Q. What are those markets?

A. McCall, Gooding, Jerome, Twin Falls. With the Saltzer acquisition they would be the dominant provider for primary care in Nampa. And they purchased the Mountain Home hospital and all the Mountain Home providers.

Q. The population of Twin Falls, it is about half that of Nampa; is that right?

A. I'm not sure of the population. Nampa is the second largest city, but I don't know the ratio.

Q. You don't know what percentage of Blue Cross members from Twin Falls leave Twin Falls for primary care; correct?

A. I have not calculated that percentage.

Q. But you do know that about 40 percent of Blue Cross's commercially-insured members in Nampa already leave Nampa for primary care; right?

A. Yes.

Q. And, in fact, over 60 percent of Blue Cross's own employees in Nampa leave Nampa for primary care; isn't that right?

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A. That would explain the reasoning why is that they work in Meridian.

Q. And if I understand your testimony from this morning regarding Twin Falls, you basically said employees in the larger community of Twin Falls were not willing to drive to the much smaller community of Jerome to get primary care; is that right?

A. That's correct.

Q. What year did the State of Idaho sign up for Blue Cross's PPO product?

A. I believe it was 2004, but I'm not clear on that date.

Q. And the doctors who were out of network, they were with a practice you said called the Physician Center?

A. Yes.

Q. So if I refer to the Physician Center, you will understand that we are talking about out-of-network doctors in the Magic Valley?

A. Yes.

Q. And at the same time that the Physician Center doctors were out of network for Blue Cross in the Magic Valley, they were in network in the Magic Valley for Regence, your competitor; is that right?

A. I assume so.

Q. Do you know whether that's the case?

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A. I can't say that I know that to be a fact.
Q. Well, when Blue Cross signed up to the State of Idaho account in around 2004, they essentially, Blue Cross, took that account away from Regence?
A. Correct.
Q. And at the time that the State of Idaho made the decision to move from Regence to the Blue Cross network, the physicians that are physicians were out of network; right?
A. I think that's what I just agreed to. They were out of network for our PPO product.
Q. So as a result, the Blue Cross PPO product in Twin Falls had I think you said only ten percent of the primary care doctors?
A. That would be a rough number. That is not an exact number.
Q. So in other words, at the time the State of Idaho signed up for the Blue Cross PPO in Twin Falls, it did so knowing that the product in Twin Falls had only ten percent of the primary care doctors?
A. Yeah, I think -- can I add a little bit of detail to that? The State of Idaho had two product offerings: a traditional product offering and a PPO. The Physician Center was in network for the traditional product. But what they found over the intervening years is that the membership, the employees of the State of Idaho did not want

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a traditional product. They wanted a PPO product.
Q. And did I understand your testimony this morning you consider the PPO product to be not commercially viable because of the absence of the Physician Center?
A. Well, it is not an on-off switch like that. There is a degree of viability. So we would not consider it to be a successful product in that market without the Physician Center.
Q. Even though you have the largest employer in the state and your largest account to sign up for that product without the Twin Falls primary care doctors?
A. They did not sign up because of Twin Falls. They signed up for the cost savings across the state. They recognized it was a problem in Twin Falls and then instructed us to correct it.
Q. So notwithstanding the fact that you had only ten percent of the primary care doctors in Twin Falls, you were able to sign up the State of Idaho account; correct?
A. Correct.
Q. And, in fact, you maintained the State of Idaho account for five years without having the Physician Center doctors in the PPO product; correct?
A. Well, it was a long-term contract so they didn't have the option of dropping out of that contract during that five-year period.

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Q. Now, the Physician Center doctors, while they weren't in your PPO product, they were in the Blue Cross traditional plan; is that correct?
A. Correct.
Q. And am I correct that the reimbursement for the PPO product, the amount that Blue Cross offers to doctors for the PPO is less than the reimbursement that they would get for being in the traditional product?
A. Not currently. It was at that time.
Q. And at the time the reimbursement from Blue Cross to providers in the PPO network was about 7 to 10 percent less than for the traditional product?
A. That sounds approximately correct.
Q. And the idea behind offering a lower amount for physicians to participate in that PPO product is that you would have a smaller network, and so those doctors could expect to have more doctors steered to them. Is that fair?
A. Generically that would be a benefit design that is true across the nation. As I mentioned earlier, many markets in Idaho and rural states really are markets that have small monopolies, so that element of direction has a smaller component.
Q. Right, because in Twin Falls the scope of the PPO product was basically with the Physician Center going to be as broad as the traditional product?

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A. That is true, yes.
Q. And what that meant was that the Twin Falls physicians were being asked to take a 7 to 10 percent discount for participating in a network that had the same scope as the traditional network?
A. There were other advantages though, the cost of membership that caused the employees to want to pick the PPO and then give a benefit to the physician for being a PPO.
Q. But in terms of the scope of the network, the PPO had about 90 to 95 percent of the providers in that area?
A. The 95 percent is our participation statewide.
Q. Was that -- that was -- that is what the participation was after the Physician Center doctors joined --
A. I haven't looked at it, but that's probably close.
Q. And that was roughly the same participation percentage as the traditional product?
A. Yes.
Q. Now, despite that fact, the Magic Valley physicians with Physician Center ultimately did agree to accept a rate lower than the traditional rate in order to participate in the PPO; correct?
A. They accepted a rate lower, plus cash.
Q. And the Physician Center physicians who Blue Cross had been trying for years unsuccessfully to join the PPO did

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so only after St. Luke's acquired their practice; correct?
A. Well, the timing occurred because of that. I'm not sure that was the cause. I would say the St. Luke's, the Physician Center physicians joined Blue Cross when we conceded to their payment demand.
Q. Right. So you had made an offer to those physicians that for years they had found unacceptable. And when you raised your offer, they ultimately agreed to a raised offer and joined the network?
A. Yes, that's true.
Q. And nobody from St. Luke's told Blue Cross that it had to extend the rates that it was paying to the Physician Center statewide; right?
A. No. I think their preference would be that we don't do that because then they would recognize that arbitrage benefit.
Q. Right. The decision to extend that increase statewide was a business decision by Blue Cross; correct?
A. Combination of a business decision and our understanding of the law.
Q. And since Blue Cross increased the statewide fee schedule to match that of the Magic Valley physicians, the Magic Valley physicians have been at the same statewide fee schedule level as other providers in this state; correct?
A. I think are you talking generally or there are

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some errors in St. Luke's billing physicians under the incorrect fee schedule; is that what you're talking about?
Q. No.
A. Or just generally?
Q. Let's back up for a second. Timing-wise, you indicated that at some point the Physician Center physicians joined the PPO product at a rate that was hire than the statewide fee schedule; right? And then Blue Cross for business reasons raised the fee schedule amount to match that of the Magic Valley physicians?
A. You keep referring to business reasons. We do have to live within the "any willing provider" law in Idaho.
Q. Fair enough. But you raised the statewide fee schedule to match the amounts that you were paying in the Magic Valley?
A. Yes.
Q. And since that time, there have been increases in the statewide fee schedule; right?
A. Some. We have split that fee schedule into different levels based on performance but some increase.
Q. The Magic Valley physicians today are not getting any more than the statewide fee schedule?
A. That's correct.
Q. Mr. Crouch, do you understand that St. Luke's could not bill for services at a facility it acquired like a

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surgery center under the main hospital's tax ID number unless the acquired facility is actually deemed an outpatient department of the hospital?
A. That is a Medicare rule I think you are referring to. That is not a rule within our contracts.
Q. And when we talked earlier about the way that contracts are negotiated, we established first there is an overall rate increase, a number that applies systemwide; correct?
A. That's correct.
Q. And then that increase is allocated across the different hospitals; right?
A. Correct.
Q. And then it is further allocated among inpatient and outpatient services; right?
A. Yes.
Q. And then within the thousands of inpatient and different outpatient services, there will be adjustments to the different codes. Some will see an increase. Some may see a decrease. But the idea is that ultimately the net of all those increases and decreases will roll up into that 5.6 percent -- or, for example, the five percent number if that is the overall number?
A. Yes, that is true.
Q. And when you sit down, when Blue Cross sits down

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to model the impact of a proposed increase, let's say you're asking yourself that should we agree to a five-percent increase, you model that based on the prior year's volume of claims; is that right?
A. That's correct.
Q. Of course, there is always a risk that the actual volume of claims is different in the following year than it was in the past, then the actual increase you experience could be more or less than you modeled?
A. That's correct.
Q. Now, once St. Luke's converted the acquired surgery centers to St. Luke's tax ID, the amount that Blue Cross began paying for services at those surgery centers was the amount that Blue Cross had already agreed in its contract to pay St. Luke's for those services; correct?
A. That is not correct.
Q. To pay St. Luke's for those services at the hospital?
A. Let me phrase it and make sure I have it correctly. So you are saying the increased fees that they received by billing through the hospital were in fact the hospitals fees, that's correct.
Q. And the reason that Blue Cross was upset was because the acquisition of the surgery centers resulted in additional volumes of surgeries being billed under the

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St. Luke's contract that hadn't been accounted for by Blue Cross when it was modeling the proposed reimbursement in the contract with St. Luke's?

A. No. I would say that that was an element. We used the -- what we considered to be bad faith because we had been in active negotiations and had asked St. Luke's to represent are there any changes in volume that we should anticipate that haven't been disclosed. They said there were no changes, and come to find out that in fact they were in the midst of negotiating that facility that had a $4 million impact to us. So we used the bad faith negotiation as a way to bring it to their attention when otherwise the would not have paid attention to our argument.

Q. But when you talk about a $4 million difference, what you are referring to is the fact that you experienced $4 million or you estimated $4 million in increased claims that you had not accounted for when you modeled the increase in reimbursement in the negotiations; correct?

A. I mean, that was an element. But the ultimate concern was that we increase costs by $4 million.

Q. Over what you had thought you had agreed to?

A. No, over what we should have been paying in the market. So the example is, we're probably all familiar, at least those who live in Boise, there's the surgery center on River Street. And that surgery center performs ENT

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services, orthopedic services, gallbladder removal, just all sort of categorized as outpatient services. We had entered into an agreement with River Street surgery center as to the payment allowances. When St. Luke's bought the facility, they billed those services as though they had occurred on Bannock Street at the Boise hospital, misrepresented the location of the service. Surely it would increase their payment.

So there were several levels of concerns we had. One of them is after reading all the blogs and the stated comments from St. Luke's about their intentions in the market, why is it that all we see is payment increases? Why aren't we seeing the cost control that they're trying to talk about? And here is yet another example of not only do they drive costs in the market, but they misrepresent the billing in such a way that it is probably fraud.

Q. Had Blue Cross known during contract negotiations that St. Luke's was acquiring surgery centers, the way that Blue Cross would have accounted for that was by taking account of the increased reimbursement for surgeries by decreasing reimbursement elsewhere; right?

A. Well, no. That is one element. Another element is there was just --

Q. I'm sorry. Is the answer yes or no?

A. Could you repeat the question.

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Q. Had Blue Cross known during contract negotiations that St. Luke's was acquiring the surgery centers, you would have accounted for that increase reimbursement by decreasing reimbursement for other procedures in that contract?

A. I think by answering yes or no you are making me commit to an item that I don't want to commit to. Because the way the --

Q. Well, Mr. Crouch, do you recall you gave a deposition in this case in May?

A. Yes, I recall that.

Q. And let me know -- we are going to play this clip, and tell me if you recall being asked this question and giving this answer.

(Video played.)

BY MR. STEIN:

Q. You were asked that question and you gave that answer in your deposition?

A. That is consistent with the answer I was just providing, which is I think your question is we simply would have changed the modeling. And my deposition answer was no, we would have said you've already achieved three and a half million dollars. We don't need to increase the allowance any further.

Q. Now, nothing in the contract between St. Luke's and Blue Cross prohibited St. Luke's from billing the

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acquired surgery centers under the hospital's tax ID; correct?

A. Could you rephrase that again.

Q. Nothing in the contract between St. Luke's and Blue Cross prohibited St. Luke's from billing the acquired surgery centers under the hospital's tax ID?

A. No, that was the point of our dispute. We believe that when we state this is a contract for St. Luke's Boise hospital, we even put the street address of the hospital and put the tax ID number in, that is a contract for that physical facility. And that is the nature of our dispute: You cannot bill other locations through that facility purely for an increase in payment.

Q. There wasn't anything in St. Luke's contracts that prohibited St. Luke's once it acquired those centers from billing them under its tax ID number; is that correct?

A. We didn't have a specific contract provision that addressed that.

Q. You were asked that question and gave that answer in your deposition, Mr. Crouch?

A. Yeah. I think I just gave the same answer which is they were billing it under a new tax ID. The tax ID for River Street would have been a separate tax ID.

Q. Now Blue Cross initially estimated the amount in dispute at $4 million?

A. That's correct.
Q. You later recalculated the estimated amount in dispute at around $3.2 million?
A. No, I wouldn't say that. We had --
Q. Thank you. St Luke's told Blue Cross that St. Luke's didn't owe anything as a result of the surgery center acquisition; is that right?
A. St. Luke's told Blue Cross that it didn't owe anything?
Q. Right.
A. Sure, that was their position.
Q. Now, I think you told Mr. Greene something to the effect that one of the reasons you didn't press the issue of the lawsuit was because of concern about St. Luke's and the size of it as a customer. But that didn't stop Blue Cross from unilaterally holding around $3 million of moneys that were owed St. Luke's for other services; right?
A. We feel we would have prevailed in that lawsuit, so that was an appropriate action to take.
Q. In fact, it was then St. Luke's that accused Blue Cross of breaching their contract for unilaterally withholding those funds; right?
A. I'm sure that's a claim they made.
Q. And Blue Cross was concerned about the time and expense that would be involved if the parties had to fight

this matter in court; right?
A. Yeah. At that point it really was just the math of are we going to obtain more through a settlement in court or is it better to just take the amount we can earn through the negotiation.
Q. And of that three point -- roughly -- strike that.
Of the amount in dispute, you ultimately recommended that Blue Cross agree to split the difference with St. Luke's; right?
A. That was in agreement as to what we thought we could obtain, not whether I thought it was the appropriate amount.
Q. Let's put up trial Exhibit 2585. Mr. Crouch, this is a series of e-mails, internal e-mails from Blue Cross in which you're involved. I want to focus on an e-mail that you sent. It's on page 2. And let's blow it up at the bottom of the page there. And can you tell me whether you in fact recognize this as an e-mail that you sent on March 17th, 2011.
A. That appears to be correct.
Q. And this is the regarding the surgery center dispute with St. Luke's?
A. Yes.
Q. And you write, "St. Luke's has completed their review of the disputed surgery center claims for 2010. They

show 1,093 surgery center claims were billed by the hospital for a total difference in allowances of $3,194,231. As you may recall, BCI estimated a $2.9 million difference in allowances and withheld that full amount in 2010."
That was accurate as far as you know at the time; correct?
A. Yes.
Q. And St. Luke's proposed that of that $3.194 million, the parties split that amount, meaning that Blue Cross's net recovery would be $1.597 million; right?
A. Correct.
Q. That is in fact the amount that the parties agreed to?
A. Yes, that's correct.
Q. And you recommended that Blue Cross agree to that compromise?
A. Yes.
Q. And the reason that you recommended to agree to the comprise -- let's look at that. "Item No. 1, negotiate the final settlement percentage. Steve Drake stated that SLHS is very firm" -- and Steve Drake works for St. Luke's?
A. Yes.
Q. "Steve Drake stated that SLHS is very firm in holding to a 50-percent settlement. FYI, we were able to obtain contract language concessions to prevent this

situation from occurring in the future, so I support a 50-percent settlement."
That's what you told your peers at Blue Cross; correct?
A. Correct. And that is in the context of what we thought we could achieve.
Q. And the settlement resulted in Blue Cross effectively paying the rates for surgeries at the surgery centers or the surgery center locations at the rates they were when they were independent for some period of time; correct?
A. I'm not sure. Say that again.
Q. When you received the -- I will withdraw.
A. Is that the $800,000?
Q. No. I am talking about the 1.5 million, 1.6 million.
A. Okay.
Q. After this dispute was resolved, in all future contract negotiations you were able to model the volume of surgeries that were done at those surgery centers when you were considering what rates to agree to with St. Luke's; correct?
A. They would have been included in the modeling, but there wouldn't have been a reduction of payment as a result of that inclusion.
Q. Right. But those volumes would have been included

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in the modeling. And when you increased -- whatever payment amount you determined would be allocated, some might be allocated at the surgery centers, might be allocated to other services, but you knew in future negotiations that these volumes were going to be occurring and billed under the St. Luke's contract?

A. So we lost that for 2012 and 2011, and then in 2013 that would have been part of the denominator.

Q. We can take that down and let's pull up Exhibit 2617. Mr. Crouch, this is a 40-plus-page document, but can you tell me whether you recognize this as a copy of the contract between St. Luke's and Blue Cross for the years 2011 and 2012?

A. Yes, that appears to be the case.

REDACTED

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REDACTED

A. That was one of the elements that led us strictly to it.

Q. By the way, this isn't a term that St. Luke's wanted added to the contract; is it?

A. No. I'm sure they did not want it to be added.

Q. And Blue Cross not only succeeded in negotiating this provision in the 2011-2012 contract, also you were able to maintain it in the most current contract with St. Luke's; correct?

A. Correct.

Q. Now, when you were involved last year in negotiating the most recent contract with St. Luke's, at the time of those negotiations you knew that St. Luke's was preceding with the acquisition of the Saltzer practice; correct?

A. Yes.

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REDACTED

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REDACTED

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REDACTED

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REDACTED

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REDACTED

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REDACTED

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Q. And that's what's known in the industry as a gain-sharing arrangement?
A. Yes.
Q. And that's distinguished from a full risk arrangement in which the provider not only stands to benefit from upside gains but can lose money in certain circumstances as well; right?
A. That is true.
Q. The arrangement that you described yesterday was that two-person group, that was a gain-sharing arrangement; is that right?
A. That was a gain-sharing arrangement.
Q. And likewise, the Medicare Advantage agreement with Saltzer also involves only upside gain-sharing; correct?
A. That is correct.
Q. Blue Cross has never had any risk-sharing arrangements with Saltzer for commercial insurance products; right?
A. They haven't had an active commercial HMO product for a number of years. So I don't recall if they were in that incentive program or not.
Q. And a two-person group couldn't possibly bear the financial risk of loss that would come with a full risk-sharing contract; right?

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A. That's correct.
Q. You have to have some scale in order to be able to take downside risk as well as upside risk?
A. Yes, that's true.
Q. And even for that two-person group, for example, while they have some upside potential, their primary form of reimbursement from Blue Cross is on a fee-for-service basis; right?
A. I think the primary form of reimbursement for all services in Idaho is fee for service.
Q. Now, earlier this year, as you explained when you were testifying in response to Mr. Greene's questions, St. Luke's and Blue Cross entered into an arrangement that provides for full risk sharing by St. Luke's, right, for Medicare Advantage product?
A. They in fact have purchased reinsurance from us, so they are not at full risk.
Q. So you would not call that a full risk product?
A. Not because we are providing reinsurance with them, no.
Q. Now, the St. Luke's Medicare Advantage contract does transition the financial risk from Blue Cross to St. Luke's; right?
A. With the exception of that reinsurance arrangement.

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Q. Right. You're not donating that reinsurance to St. Luke's. They have to pay for that; right?
A. That is correct. But that means they're not accepting that risk at that point. They're transferring it back to us.
Q. Well, they are insuring part of the risk. That's no different than obtaining coverage for catastrophic care.
A. Yeah, I'm sorry. You were using the term full risk. I was trying to clarify that it was partial.
Q. Now, under the agreement with St. Luke's, did I understand you to testify in response to Mr. Greene's questions that Blue Cross has no profitability at all under that contract?
A. We don't know until the end of the year whether we have had profitability, and it is still early.
Q. Doesn't that contract provide for reimbursement to Blue Cross for the cost of its administrative activities, plus a profit of two percent?
A. That was St. Luke's language that they believed it was. We have never agreed to that.
Q. So I'm sorry. I don't understand. You're saying St. Luke's offered two-percent profit and you don't agree with that?
A. No. I am saying that St. Luke's has described it as they have provided us with our administrative costs plus

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two-percent administrative profit. We have not agreed with them on that point.
Q. If St. Luke's succeed in controlling costs as a healthcare provider, St. Luke's is going to reap the benefits of that under the Medicare Advantage product; correct?
A. If that were to occur, the curiosity is that Blue Cross continues to perform all the medical management functions under that contract.
Q. You were not satisfied with the risk contract that you signed with St. Luke's because it eliminated Blue Cross's profitability under the medical component of the contract; right?
A. That was one element. The second element is that they left us to do what we call all the heavy lifting. They took the profit.
Q. So can you just clarify that for the court, Mr. Crouch. Is it your testimony that St. Luke's isn't really doing anything to address how services are utilized under the Medicare Advantage product; they are really just relying on the good work of Blue Cross?
A. The standard methods for managing utilization are prior authorizations for surgeries, prior authorizations for imaging, current review of inpatient admissions, the arrangement of contracted rates for care after discharge,

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making sure that people go home after a hip replacement instead of going to a rehab facility. Those are all activities that we continue to perform.

Q. And St. Luke's is performing no utilization-reducing activities of its own?

A. If they are performing those activities, I can't speak to that. I'm not aware of them.

Q. Now, Mr. Greene asked you a question yesterday to the effect of whether you were aware of any risk-based contracts that St. Luke's refused to enter into with Blue Cross. I found that kind of interesting phasing. And you said St. Luke's rejected Blue Cross's request that it agree to a ConnectedCare product; right?

A. Yes.

Q. Let's talk about the reasons St. Luke's rejected that. St. Luke's rejected the ConnectedCare product, which would have been a new product; right?

A. Yes, new to the market.

Q. That would have sat side by side with the PPO product and the Medicare Advantage product?

A. No. Would have sat side by side with the PPO product.

Q. Right. And the reason St. Luke's rejected the ConnectedCare product is because it wanted a broader risk-sharing arrangement covering all products, commercial and

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Medicare; right?

A. It had proposed -- St. Luke's had stated the reason they didn't contract for ConnectedCare was that they did not want to compete over price with Saint Al's.

Q. Let's pull up Trial Exhibit 2587, Mr. Crouch. Do you recognize this? Let's pull it up.

A. Can you zoom it a little.

Q. This is an e-mail that you sent to Ms. Geyer-Sylvia January 20th of 2012; correct?

A. Yes, correct.

Q. And in the second paragraph you say, quote, "As you may recall, BCI previously proposed the ConnectedCare concept to St. Luke's, but they rejected that approach in favor of an all product arrangement."

That is what you wrote; right?

A. Yes.

Q. And an all product arrangement means an arrangement covering all of the products that St. Luke's has with Blue Cross commercial and Medicare?

A. Correct.

Q. In fact, St. Luke's proposed a broader relationship under which a majority of St. Luke's compensation would be risk-based by 2017; right?

A. That is -- yes, that is what they were stating.

Q. And that all products arrangement would have

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involved a broader risk-sharing arrangement than just a discrete ConnectedCare product or bundled payments; right?

A. In the 2013 contract, they provided further examples where they requested that Blue Cross of Idaho only allow certain high profitable services to be directed into St. Luke's under what we would consider the guise of a risk-sharing product, which in fact was to eliminate the ability for St. Al's or Treasure Valley or other providers to perform sleep lab studies, surgical procedures, orthopedic services, or spine fusions. So they were using the correct terminology, but when you looked at the details of their proposal, it wasn't what we would consider to be an ACO.

Q. Let's take a look at the proposal, page 2.

A. Yes.

Q. This is a document that Mr. Billings sent you describing what St. Luke's was looking for in relationship with a payor?

A. Okay. Yes, I have it.

Q. And George, if we can pull up that section in the middle of the page.

He told you -- Mr. Billings told you they wanted a long-term relationship, a long-term commitment; is that right?

A. Yes. I see it there stated.

Q. He told you he wanted a commitment to a

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traditional model of shared shavings for the population management model; right?

A. Should we define shared savings?

Q. He told you he wanted complete data sharing between the parties, more transparent data sharing; right?

A. Yes.

Q. And then in No. 6 there, we see the progression to the majority risk-sharing model. That's something else Mr. Billings proposed?

A. Yes.

Q. And then No. 8, one of the things that Mr. Billings insisted on was transition to control of the premium value, meaning that the shared savings would not go to Blue Cross's insurance reserve, but would go to lower premiums; right?

A. Let me read eight. So, again, looking at the document, they are phrasing in such a way to use jargon which makes it sound like its appropriate, but what they really requested here is that we distribute profits to St. Luke's without them taking a risk until some undetermined model would develop by 017.

Q. Right. So you're saying when he said majority risk-sharing model, that really didn't mean majority risk-sharing model?

A. No. I am saying that at that point they would

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have had a share of whatever those profits would have been, so they are asking us to commit distribution of profits without them committing to the model of the risk arrangement.

Q. The statement that you have repeated over and over that Mr. Billings told you that St. Luke's didn't want to compete with Saint Al's on price, isn't it true what Mr. Billings has explained to you on several occasions is that what St. Luke's doesn't want to do is just perpetuate the discounted fee-for-service paradigm but rather move to a more population management-based, risk-based arrangement?

A. They have said that, but they haven't agreed to any of the proposals that would be a transition to a risk arrangement.

Q. Not with Blue Cross?

A. Not with Blue Cross.

Q. Now, regarding the analysis that you did of the Saltzer volumes and the analysis of what those would look like reimbursement under the St. Luke's contract, am I correct that that analysis assumes no change in utilization of services when Saltzer affiliates with St. Luke's?

A. That is correct.

Q. But you know the independent physicians who own their own imaging devices utilize imaging at a higher rate than physicians that don't own their own imaging devices;

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right?

A. In the context of that reference, though, a hospital-owned provider is considered an owner of imaging devices.

Q. Independent physicians who own their own imaging devices utilize imaging at a higher rate than physicians who don't own their own imaging equipment?

A. Than independent physicians who don't own imaging devices.

Q. And Blue Cross has provided claims data to a researcher at Georgetown University to study the impact of physician ownership on utilization; right?

A. Yes, we did.

Q. That is an issue that's important to Blue Cross. Utilization affects the cost just as much as the unit price; right?

A. Yes.

Q. And that researcher, is that Jean Mitchell?

A. Yes, that sounds correct.

Q. And her study demonstrated that independent physicians who own their own imaging devices utilize imaging at a higher rate than physicians who don't; is that right?

A. That is correct. And St. Luke's supported that study as well.

Q. They supported conducting that study?

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A. Yes.

Q. And you believe those conclusions to be true both nationally and in Idaho; is that right?

A. With the caveat I was stating that independent physicians -- we are talking only about independent physicians.

Q. Now the reason that utilization in physician-owned centers is higher is because the physicians have a financial interest in the utilization of those services; is that right?

A. That's true.

Q. But yesterday and this morning you mentioned the North Idaho Physicians Network, a network of providers in north Idaho?

A. Yes.

Q. Isn't it true that the North Idaho Physicians Network specifically excludes physician-owned hospitals from the network?

A. There is one physician-owned hospital network that is excluded.

Q. Are you familiar with Ms. Mitchell's study on the effects of physician ownership of specialty hospitals and ambulatory surgery centers and the frequency of use of orthopedic surgeries?

A. I have read it, it would have been many years ago.

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Q. This is a copy of that study that interestingly is on North Idaho Health Network's website. I believe you testified you have read this, but it has been some time.

A. And what was the publish date?

Q. It was published in 2010 in the Archives of Surgery.

A. I'm not sure I even read this version of the study.

Q. You're not sure?

A. Yeah, I don't recall if I have or not.

Q. Okay. So let me just ask you then -- George, if we can go down to the section on results.

MR. ETTINGER: Your Honor, if he hasn't read it and it's some third-party study, this is hearsay.

MR. STEIN: I'm trying to establish if he recalls.

THE COURT: I will give you some leeway. If witness has not seen it, then he cannot very well be cross-examined on it.

MR. STEIN: Right.

BY MR. STEIN:

Q. So, Mr. Crouch, if you can look at the results here and let me know whether this refreshes your recollection whether you have seen this study before.

A. I am recalling the study that Jean Mitchell performed in Idaho was independent physicians and their use

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of imaging. This appears to be a different study.
Q. Okay.
A. I am happy to comment on it if you are interested in commentary, though.
Q. Mr. Crouch, you testified that Blue Cross's commercial rates are substantially higher than the Idaho adjusted Medicare fee schedules; is that right?
A. Are you talking about for physician services?
Q. Yes.
A. Yes.
Q. Isn't it true that the rates that Medicare pays physicians in Idaho are among the lowest in the nation?
A. Medicare makes geographic price adjustments based on the cost of running an office. And Idaho is a low cost area, so those adjustments apply to Idaho.
Q. So the rates that Medicare pays Idaho physicians are among the lowest in the nation; correct?
A. Let me state there are two components. The rate Medicare pays for physicians for physician services are the same. The rates they pay physicians for office overhead is lower.
Q. Now, you testified yesterday about an article that you reviewed in this month's Health Affairs that you relied on in your conclusion that Blue Cross's payments are higher than national payments; is that right?

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A. I have had that opinion for many years, but this month's Health Affairs confirmed that opinion.
Q. But that article, that looked at payment rates in the year 2007; right?
A. Yes.
Q. And the comparison that you described was in national payment rates in 2007 versus Blue Cross's rates in 2007?
A. Yes.
Q. And you also reference Milliman studies that Blue Cross commissioned as supporting your understanding of the relationship between Blue Cross fees and Medicare; is that right?
A. Yes.
Q. And one of those Milliman studies was from 2008; is that right?
A. Yes.
Q. Like the Health Affairs article, that was using data from the year 2007?
A. Yes.
Q. And the most recent Milliman study that Blue Cross commissioned actually shows that Blue Cross's physician fees are about a five percent less than the market rate in Idaho; is that right?
A. I need to provide a little bit of context.

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Q. Mr. Crouch, can you answer my question?
A. I would say no.
Q. So let's look at trial Exhibit 2588. And this is a letter that Milliman sent to you on April 12, 2012; right?
A. Yes.
Q. And in the top paragraph there it says, "Dear Jeff, at your request, Milliman has compared Blue Cross of Idaho physician-allowed fees to benchmark data for calendar year 2010." Correct?
A. Yes.
Q. That was something you asked Milliman to do?
A. Yes, we did.
Q. Then if we go to page 2 in the second paragraph, Milliman reports back to you that, quote, "According to the data, BCI fee levels were 4.7 percent less than the average market scan of Idaho fee levels across all Idaho areas." Correct?
A. Correct. The way you phrased the question earlier was market rates. I think you might be confusing market scan which is a database for market rates.
Q. And if we go down under the first table, Milliman further explains that "Table 1B shows that BCI's physician unit cost reimbursement rates are lower than market scan for Idaho, Portland, Montana, Oregon, Utah, Washington, but higher than market scan reimbursement levels for Spokane,

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Seattle, and Salt Lake City." Correct?
A. Correct.
Q. Now, one of the things that your staff has done is to prepare a document that tracks acquisitions of physician practices by St. Luke's; is that right?
A. Yes.
Q. Around one of the things that you track in that document is the effect of St. Luke's acquisition of the physician practice on the amounts that Blue Cross pays to that practice, doctors affiliated with that practice for physician services; right?
A. That is correct.
Q. And that analysis by Blue Cross shows that every single acquisition by St. Luke's of a physician practice in the Treasure Valley has led to either no change in physician service reimbursement or has decreased the rates that Blue Cross pays for physician services to that practice; correct?
A. That is incorrect. That is incorrect.
Q. Let's take a look at Exhibit 2148. Mr. Crouch, this is an e-mail from Laurie Rowell to Stina Proctor. These are Blue Cross employees; is that right?
A. Yes, that's correct.
Q. And there is an attachment referenced here. George, could you go to the first page of that attachment and pull up the top few lines so we can see the headings of

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the first few rows.
This is the analysis that we were just discussing of the charts; is that right?
A. Yes.
Q. And. In the left column it says "Acquisition Date." That is the date St. Luke's acquired the practice; is that right?
A. Yes.
Q. Then the next column says "Clinic Name." That is the name of the practice that was acquired?
A. Yes.
Q. Next to that there is a "Provider Type or Specialty"; is that right?
A. Yes.
Q. And then if we go over to the second-to-last column, it says "Immediate Reimbursement Change Commercial"; right?
A. Yes.
Q. And that column shows what happens to the rate that St. Luke's has to pay for services of the acquired practice under commercial plans once St. Luke's acquires the practice; is that correct?
A. That's correct.
Q. And there are basically three options: Increase, meaning the rates that Blue Cross pays for physician

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services go up; none, meaning there's no change; or decrease, meaning the rate Blue Cross pays for physician services by those acquired practices goes down; right?
A. Correct.
Q. We can go through line by line, but every line in this document for acquisition of a physician practice shows that the immediate change in commercial reimbursement was either none or a decrease; right?
A. Incorrect.
Q. Why don't you show me where I'm --
A. You are missing the third-to-the-last column.
Q. No. I'm not asking about the third-to-the-last column. I am asking about the last column, which refers to commercial.
A. Your question to me earlier was whether the acquisition of a physician practice always results in a decrease or no change, and that is incorrect. For almost in every example it results in an increase for Medicare. This document, if we've configured the physician correctly in our system, there should be no change in compensation. As you talked about earlier, the fee schedule is the same across the state. So if we have identified there is an increase or decrease in the second-to-the-last column, that indicates we have either configured them incorrectly or St. Luke's is billing them incorrectly.

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Q. Mr. Crouch, this document shows that acquisition of physician practices by St. Luke's have resulted in no increase in physician fees paid by Blue Cross for commercial plans?
A. I need to phrase that a little bit differently. So we talked about earlier, St. Luke's has demanded through hospital negotiations that we increase fees for professional practices.
Q. Mr. Crouch, I am going to play another clip from your deposition. You seem to have trouble remembering your prior testimony. Exhibit 39.
A. I was apparently asleep during part of the deposition.
(Video played.)
BY MR. STEIN:
Q. Mr. Crouch, you also gave this testimony.
(Video played.)
BY MR. STEIN:
Q. Mr. Crouch, you also gave this testimony.
(Video played.)
Q. You were asked that question and gave that answer, Mr. Crouch?
A. Yes. And the question was whether this document shows an increase or decrease, not whether payments to physicians increased or decreased as a result of St. Luke's.

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MR. STEIN: Your Honor, at this time the only things I think I have left outstanding are the issue with the Dykeman report and Exhibit 1301?
THE COURT: 1300.
MR. STEIN: Otherwise I have no further questions at this time.
THE COURT: Were you going to examine further with regard to Exhibit 1300 in preparation?
MR. STEIN: I'm sorry.
THE COURT: Were you going to examine further with regard to Exhibit 1300 and the method by which it was created or otherwise seen?
MR. STEIN: I don't think so, Your Honor. I think we established it was created using statewide data we do not have access to, so really however it was calculated we do not have any way of evaluating it. That's really the issue.
THE COURT: What you were provided as I understand it was the St. Luke's data points, but none of the other hospital facilities.
MR STEIN: That is correct. Again, we approached this keeping in mind the point of this analysis is to compare us to other hospitals statewide. So without the statewide data, it makes it a little difficult. It is the relative position of St. Luke's versus those other hospitals for which the document's being introduced. So without the

other data, I'm not really sure what it is that we could do.

We couldn't do an alternative analysis that would show that if you made a different assumption, we might actually be in a different position vis-à-vis those other hospitals. We don't have that ability. We just have to take the results of the study that they gave us, and we can look at that and maybe take little things here and there. We certainly don't have a full opportunity to do alternative analysis. I would submit, if this were an expert report, my hope would be that it wouldn't possibly come in. We don't have the information needed to evaluate it.

THE COURT: This is my thought about this. In fact, Mr. Metcalf and I were having a somewhat I don't want to say heated but at the same time exchange here going back and forth on that issue. And I asked questions to establish that this was indeed a business record. And of course the concept of a business record is a bit of a misnomer because I think it has been misused so often it's really the record of regularly conducted business activities or something like that. The concept is when an entity records information, and even I guess compiles that information in various formats, in a way they actually rely upon it, that there is a sufficient measure of credibility that we can forego cross-examination for the admission of the exhibit itself.

Now the problem of course is that even when an exhibit

comes in under Rule 8036, the party opposing the admission has the ability to call the person who actually prepared the data, cross-examine that person about the accuracy and the process by which they actually produced the report, the rigors of being an 8036 document, and that is what is missing here.

However, it is a problem that cuts both ways. This is not a situation, for example, where it is a Saint Al's or a Treasure Valley document so that it would be terribly unfair to allow them to offer an exhibit without the ability to cross-examine the preparer of the document and determine what the methodology was that was used in creating it. But here, Saint Al's and Treasure Valley and the FTC -- I suppose I can say they are innocent bystanders. They want to use the document. They are under the same impediment St. Luke's is as far as not being able to actually bring in the data that would then satisfy those concerns.

So then as I thought about it, perhaps it comes back to a Rule 403 analysis. Typically when we think of the prejudicial impact, we think of something that creates too much sympathy or something of that sort, but it seems to me it probably is applicable as well here. So you could say that if the probative value is not substantially outweighed by whatever prejudicial impediments there are to the opposing party to examine the accuracy of the underlying

data, should the Court allow it in? And I think I need to hear from Mr. Greene as to what the probative value is because they are essentially the same position that St. Luke's is, although they want to have the evidence in, they think it is probative, and they are somewhat handicapped because they cannot show that the numbers are equally out of whack and then perhaps St. Luke's position is even more out of the mainstream than what Blue Cross is suggesting.

Mr. Greene, do you want --

MR. GREENE: Two levels of analysis, Your Honor. First is the equities level as I mentioned earlier. When we were not in trial, St. Luke's actually brought a motion to compel production to resolve against them. They did not decide to come to Your Honor to sort this out nor did they at that time raise these issues. So I think there's that problem.

The basic underlying --

THE COURT: Let me just address that. As we noted earlier, a question of discovery is not the same as a question of admissibility during a trial.

MR. GREENE: No, understood, Your Honor, but this is the problem that puts us in the situation that we are in. They didn't get this resolved at a point in time when we could actually fix it. Now we are in trial. They have just

raised this matter. They could have raised this earlier in a far more effective way. That is one level.

The second level is that all the parties, largely because of the burden it imposed on Blue Cross of Idaho, agreed to the fatal limitations which Mr. Stein is now complaining about. So this again is a situation in which St. Luke's participated in the process fully. They agreed to this. There are certain e-mails and other conversations that support that idea. So I think that is part of it because we are in a balancing test situation.

With respect to its evidentiary value, what Mr. Crouch and his document speak to is a dramatic upshift in the cost of services at St. Luke's in its major facilities. One of the major arguments that we have heard from the defense in its advocacy throughout the case but certainly most recently in its pretrial memorandum is that the offset what we regard as the massive increase to Nampa is going to be efficiencies. Mr. Crouch's document goes directly to the heart of that matter by indicating the cost at those facilities, without any change in case mix or anything else, have gone up quite dramatically. Some of the most expensive in the market.

I don't know that this decides the case, but it certainly is directly contrary to the story line that St. Luke's would have the Court believe. So we think it is

worthwhile. It is useful. It does have some inherent limitations, but I think at the end of the day it is far more beneficial to the Court to see and hear actual data that indicates that St. Luke's puffery from our perspective you will appreciate is simply not based on reality. And this does cover a pretty substantial period of time. I mean it goes from 2008 to 2012 and shows quite dramatically that efficiencies they had they certainly haven't found them.

THE COURT: Response?

MR. STEIN: I actually think the document shows the opposite. What it shows as we demonstrated before, is that there are other hospitals, of course, identities unknown, that are getting the same reimbursement as St. Luke's facility in particular. I know the plaintiffs like to focus on Magic Valley. We are talking her about the Treasure Valley. We are talking about Boise and Meridian and you saw three other hospitals that are getting the same or higher reimbursement than St. Luke's in Boise. So far from supporting the plaintiffs' case on that point, I think it actually supports our point that price increases occur for a variety of reasons and that one cannot simply infer from a price increase that there's been anti-competitive conduct.

Again, the point is we are limited in our ability to address this. As far as the motion to compel goes, I am

certain we did not get any support when we asked the judge to require us to produce this from the Federal Trade Commercial. But the bottom line is: It wasn't our decision to include the document on a trial exhibit list. That wasn't before Judge Bush and it wasn't something that we addressed at the time. It's true, we are now here at trial, and that's why I think frankly the prejudice is all the more manifest.

THE COURT: I think Judge Bush's decision really is not relevant. I don't think anyone could have or should have anticipated this issue during discovery that it would require that in fact some appeal be taken or that somehow they try to address the issue. Discovery is one thing and admission to trial is really quite another.

However, I am going to admit the exhibit. I think it does fall within Rule 8036. I think it provides sufficient guarantees of reliability because Blue Cross in fact depended upon that information in making the most critical business decisions. I will concede that there is some prejudice. The prejudice really is to both parties. Neither party has the ability to test it beyond the ability which I would point out that they do have presumably to compare reimbursements rates and percentages against at least their own data. I recall having three facilities on that list, Saint Al's having a fourth. Even though I think

it is a difficult problem, I just want you to know Mr. Metcalf and I spent a fair amount of time exchanging same time messages debating the issue. But I am going to admit the exhibit over objection of counsel.

(Whereupon, Plaintiffs' Exhibit No. 1300 was admitted into evidence.)

I think that covers it. Is there anything else, Mr. Stein, that you want to --

MR. STEIN: I think we just have the issue of the reference to the Dykeman article. I'm not sure whether Mr. Green wanted to discuss that.

THE COURT: We can discuss that if there is a need. You will have a chance to look at the daily transcript. If indeed there is some reference to testimony that you want stricken because you have not had an opportunity to examine on that, unless Mr. Crouch is recalled, I guess that is the other option, but in any event, let's move on to redirect then.

Whereupon,

Mr. Greene, redirect.

MR. STEIN: Your Honor, some of these exhibits used with Mr. Crouch, can we have leave to do that at the end of the day?

THE COURT: Yes, certainly. I'm going to be very flexible about those kind of housekeeping matters. Make

sure we don't go into the second or third day. My memory will lag, although I'm trying to take fairly good notes as exhibits are referenced.

Mr. Greene.

REDIRECT EXAMINATION

QUESTIONS BY MR. GREENE:

Q. If I could have Exhibit 2148. Showing you Exhibit 2148, this is a document Mr. Stein was examining you on a moment ago. You seem to resist the notion that this somehow indicated that the result of acquisitions by St. Luke's of independent practice groups resulted in no change in cost to BCI. Why is that?

MR. STEIN: Object to form. I did not ask about cost. I asked about physician services for commercial.

THE COURT: Counsel, would you rephrase the question. I wasn't sure we'd have an objection on the first question. Wasn't paying enough intention. So could you rephrase. And bear in mind Mr. Stein's objection.

MR. GREENE: Of course.

BY MR. GREENE:

Q. With respect to Mr. Stein's questions with respect to this document, when it says "None," what does that relate to specifically?

A. Well, the concern I had is a representation that the acquisition of physician practices does not increase

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costs for Blue Cross of Idaho. And that is an area that I would disagree with.

Q. And why is that?

MR. STEIN: I would move to strike. That's not the question I asked.

THE REPORTER: I can't hear.

THE COURT: Let's go one at a time. I am going to overrule the objection. Go ahead and proceed.

BY MR. GREENE:

Q. Let's do this a different way. Is it appropriate to draw the conclusion from this document where it says none, that there are no cost increases to BCI because of an acquisition of a physician group?

A. No. That is not an appropriate result.

Q. And why is that?

A. Hospitals buy physician practices not to increase physician reimbursement. They buy physician practices to increase hospital reimbursement. So as a practice is acquired, the fees paid to that physician are not going to change. We pay them on a standardized fee schedule. What will happen is that the referrals from that physician practice will now be referred to specialists owned by St. Luke's, and all of the ancillary services that were previously referred out to community providers of what we call commodity rates would be referred into the St. Luke's

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hospital.

So the immediate impact for outpatient surgery is our costs go up 289 percent in the study we looked at earlier. For ancillary services such as labs, PT, imaging, they will go up 32 percent to over 40 percent depending on the product you are looking at.

Q. Now, during the course of the conversation with Mr. Stein, you discuss something called provider-based billing. And I believe you also mentioned a notion called hospital-based billing? What is from your perspective provider-based billing?

A. In the Medicare world they changed their policy a number of years ago. It is now believed by MedPAC and others to have been an ill-advised policy. Nonetheless, they changed the policy a number of years ago to state that if a physician's practice is owned by a hospital, the hospital can also bill a fee for office visits. That is what commonly would be referred to as facility-based building or provider-based billing.

Q. When you pay higher charges when an independent physician group is acquired by a hospital, here at St. Luke's, what would one call that pricing structure? Is that referred to as hospital-based billing or some other phrase?

A. I think it would create confusion to call that --

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even though it's billing from the hospital, that would be a transition of billing for services that previously had been performed in the community by freestanding centers to services performed by the hospital through their outpatient department. I'm not sure that there's a general reference other than we normally refer to that as commodities going from a low cost setting to a high cost setting to high.

Q. So there's no ordinary term or phase that we can use in this proceeding that describes the higher rate that you pay?

A. You could use hospital-based billings as long as it is differentiated from that notion of provider-based fees, which are a little bit of a nuance of the Medicare system.

Q. So if we wanted to keep this straight in our own minds, provider-based billing would be associated with Medicare changes, and hospital-based billing would be associated with higher charges that might be associated with payments from a commercial payor like yourself?

A. I think that seems to be a fair use.

Q. Back to this initial notion. Is your primary concern about the Saltzer deal that the physician component of fees would go up dramatically or is it something else?

A. The immediate impact is that physician fees or fees that were billed from the physician would now be billed

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by the hospital, those charges would go up. The fee itself as we identified through this audit document we had, the payment for the physician service on a commercial product should not change if everything has been configured correctly. The concern in the mid-term is the cost will increase. The concern in the long-term for Saltzer is that St. Luke's will drop Saltzer out of our ConnectedCare network and out of the Saint Al's Alliance Network and they'll only be available through the BrightPath Network and through Select Health.

Q. While we are sorting out nomenclature, how would you distinguish the professional fee from an ancillary fee?

A. So a professional fee is for a person service, a physician, for example, has a professional fee. An ancillary, and this -- I might be taking a little bit of liberty here just because that is the nomenclature I have been using. An ancillary service is a service that's ancillary to the professional's activity or to the hospital's activity.

THE COURT: Counsel, I want to back up ask the witness to explain something. You were asked earlier I think as I understood your testimony the acquisition of doctor practices did not result in increasing the doctor's rate of reimbursement, but that the cost increase came from moving the reimbursement for ancillary services and I think

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you referred to as commodity rates from community groups to the hospital in which there were substantial increases in those rates; is that correct?

THE WITNESS: That is correct.

THE COURT: Now are you saying the same thing about your primary and initial concern about the Saltzer acquisition? I understood you to say that you were concerned that actually the billings rates themselves for the physicians would also increase when charged through the hospitals. Did I misunderstand that last part?

THE WITNESS: The physician services won't be billed through the hospital.

THE COURT: So it is the same issue.

THE WITNESS: Yes.

THE COURT: In essence, kind of the ancillary services and the other services that are ancillary to the primary physician care where the rates will substantially change when they are build through a hospital, and we discussed the reasons for that earlier when we talked about maintaining the lab 24/7, maintaining diagnostic centers 24/7. That is a primary concern, not a change in rates themselves, for the physician?

THE WITNESS: That is true for commercial. For Medicare there is in fact a change in the rate of physician fees. So there is that one difference.

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THE COURT: Medicare not at issue here.

THE WITNESS: No.

THE COURT: Thank you. I just wanted to understand that. Go ahead.

MR. GREENE: Thank you, Your Honor.

BY MR. GREENE:

Q. Just a couple clarifications, Mr. Crouch. With respect to Twin Falls, did St. Luke's position in the Magic Valley affect the ability to seek higher reimbursements from BCI?

A. Higher reimbursements from physicians or from hospitals or both?

Q. Both, but focus specifically on physicians.

A. So we do -- I would say the acquisition of physician practices by St. Luke's has allowed St. Luke's to demand higher fees for physicians in general. So that is not an immediate impact of an acquisition, but St. Luke's now employs 500 or so physicians in the state. So they have been able to demand through their hospital contract that we increase our physician fee schedules.

Q. That raises another question. During the course of the conversation with Mr. Stein, he described a structure in which you and St. Luke's could put increased reimbursement rates pretty much anywhere in the system; is that correct?

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A. Yes.

Q. And is that a typical practice?

A. No. St. Luke's is the only provider that we have been persuaded to negotiate to that level.

Q. So would it be the case that if there were greater market power say in Nampa, instead of increasing rates for physicians in Nampa, it could be taken in the price of, I don't know, maternity care?

A. Yes. The point I made earlier is that combining whatever leverage they have with the hospital and whatever leverage they have with the physicians leads to higher payments for both because we are recognizing that we have to -- I mean, in Chuck Pomeroy's comments in one of his e-mails is when they changed their strategy to say we are now contracting with Blue Cross for all products, for all providers at the same time, they won't allow separate negotiations for physicians or facilities. It's bundled into package of all or nothing for us. That is when I think we felt like we really had few options.

Q. Then turning briefly back to Twin Falls, this ability to seek higher rates from BCI, was that a reflection of the BATNA analysis?

A. Certainly that describes what we were thinking when we were looking amongst ourselves and saying well, if this doesn't come about, what are we going to be left with?

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Q. And in effect, did that change the leverage, if you will, of St. Luke's in the negotiations with BCI?

MR. STEIN: Objection, leading.

THE COURT: Overruled.

THE WITNESS: Every time St. Luke's acquires another hospital or another physician group they increase market position so Magic Valley would be an example of that.

BY MR. GREENE:

Q. Did the change in that negotiating leverage result in higher reimbursements paid by BCI to St. Luke's?

A. Yes. We believe that is exactly what it led to.

Q. Generally on this question of market power, how would you compare St. Luke's market power with that of Saint Al's?

A. That is an interesting question. If I look at it just purely from dollars, St. Luke's is more than three times of the size of Saint Al's. So in that regard, if dollars were of equal value, they would have three times the value. If you look at it by the markets they control, Saint Al's does not control a single market other than say for hospital services in Nampa. Outside of that small niche category, Saint Al's is in a competitive marketplace. St. Luke's on the other hand is the only supplier or the majority supplier of hospital and professional services in many markets in Idaho.

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Q. At the end of the day, how does the Saltzer transaction affects St. Luke's market power?

A. I think it adds to the list. So St. Luke's is the dominant provider or only provider in McCall, in the Wood River, in Jerome, in Gooding, in Twin Falls, in Mountain Home, and they are obviously the dominant provider in Boise. That extends their reach to one more market, and that would include the Nampa market.

Q. Then historically, Mr. Stein chatted with you about the give and take of the negotiating process. And I believe you previously testified that you are paying more because of some of these acquisitions. What did you get when you gave up those higher reimbursements for the surgery centers in Magic Valley? If there was a give and if there was a take from St. Luke's, what did you get out of that dealing?

A. Well, the consideration we obtained out of that contract was their continued participation. It would have been modest concessions that might have had value to us that might not have had value to St. Luke's, so we considered that a gain to the negotiation. They may not have considered that to be a concession. That often happens in negotiations.

Q. Does St. Luke's acquisition of Saltzer affect St. Luke's ability to obtain higher reimbursements?

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A. Yes.

Q. Do you expect St. Luke's to be able to obtain higher reimbursements from BCI as a result of this acquisition?

A. Yes.

Q. Is that because BATNA is less attractive as a result of this transaction?

A. In that case our BATNA, we have to walk away from markets where St. Luke's is the only provider.

Q. Does this dynamic apply to negotiation of a risk-based contract as well?

A. Yes.

MR. GREENE: I have no further questions, Your Honor.

THE COURT: Any recross?

MR. POWERS: I have one question follow up on a question Mr. Greene had.

THE COURT: I will permit it. Go ahead.

CROSS-EXAMINATION

QUESTIONS BY MR. POWERS:

Q. My name is Ray Powers. I represent Treasure Valley Hospital. Mr. Stein asked you some questions about utilization, and the conversation generally or the discussion generally had to do with utilization of imaging studies at physician-owned facilities. There was also

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discussion about utilization at physician-owned surgical hospitals. And you seemed to want to interject in answering those questions and make a distinction about independent physicians. Do you recall that give and take with Mr. Stein?

A. Yes.

Q. Can you help the Court understand why it was important for you to make that distinction about independent physicians in that discussion.

A. The distinction I wanted to make is when a physician becomes acquired by a hospital, they share the characteristics of owning their own equipment because the physician is compensated based on their referrals and what they generate.

Q. Elaborate on that just a bit more, realizing that we are all trying to get familiar with these issues.

A. So I am speaking in general terms. I should not represent that I know what the arrangements are with Treasure Valley or Saint Al's or St. Luke's. I am just familiar with how the mechanics work generally.

But if a physician is an independent provider, let's say an independent OB-GYN doc, and you are providing primary care for moms who are pregnant, and you are delivering babies, once you are acquired by a hospital, there is an expectation, it probably is even in the

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contract, but there is certainly an understanding that you are going to deliver your babies at the hospital that employs you. That applies to all services the physician may provide. There is an expectation, whether it is in writing or in fact it is just implied, that when you send your labs out, you send it to the hospital.

MR. STEIN: Your Honor, I object on foundation. This is just pure speculation of this witness.

THE COURT: Counsel, I'm not sure he would be able to, from his vantage point with BCI, how he would understand that expectation. So I would have to sustain the objection.

MR. POWERS: Let me ask a follow-up question. Maybe we can lay the proper foundation, Your Honor.

BY MR. POWERS:

Q. As part of BCI's efforts, they track utilization; correct?

A. Yes.

Q. Utilization is important to you; correct?

A. That's correct.

Q. And you track utilization in hospitals, and you track utilization of independent physicians; correct?

A. That is correct.

Q. And in the course of tracking utilization, one of the things that you are familiar with is the way independent physicians -- one of the things you are familiar with is the

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practice of independent physicians when it comes to utilizing services such as imaging studies and the practice of those independent physicians once they are acquired by a hospital in terms of how they use and rely upon imaging studies; correct?

A. That's correct.

Q. Okay. The testimony you have already given I take it is based upon that knowledge of tracking utilization; correct?

A. Yes.

MR. POWERS: Your Honor, I would like his answer to stand, and I'd like him to be able to continue his answer based on that foundation.

THE COURT: The witness can testify as to what the tracking utilization by BCI actually revealed, but in terms of what the actual dynamic is or the expectation is, I don't think he can testify as to that. Can you still offer anything limited only to information that BCI tracks in terms of actual utilization?

THE WITNESS: I will give an example. We monitor our emergency room usage across the state. Bench market would be how many emergency department visits per thousand members per year in a region. In the state of Idaho, the average number of emergency department visits per thousand members per year is 119.

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When we look at the variation across the state though, we see areas of high utilization and areas of low utilization. The area of highest utilization is the Magic Valley, 147 ER visits per thousand members per year. The area of lowest utilization is Idaho Falls, which is 89 visits per thousand members per year.

ER utilization is thought to be an indicator of access and availability to primary care. One of the St. Luke's competitors here in Boise attempted to open up an urgent care center in Magic Valley, that urgent care center -- and this is my understanding of conversations with that provider.

MR. STEIN: Objection, hearsay. And I think we are beyond the scope, Your Honor. We are going to be getting into this --

THE COURT: How is this tied back in?

MR. POWERS: It ties back into the concept of utilization. Mr. Stein introduced evidence suggesting that there is over-utilization, not only of imaging studies, but other facilities and other studies at hospitals that are either owned by physicians or have a physician interest. And I think the witness as he was being questioned was trying to draw a distinction between over-utilization by independent physicians versus physician-owned facilities. And I think he is trying to elaborate on that and help the

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Court understand the difference between the two and what BCI sees with the issue of utilization once a physician becomes affiliated with their own hospital.

THE COURT: I will sustain the objection as hearsay. The witness can still offer whatever information he can from information he observed at BCI that they collected in order to make their business decisions.

Proceed.

THE WITNESS: There is a bunch of questions here. I am not sure I am addressing the specific question. Maybe you could phrase the question for me.

BY MR. POWERS:

Q. Sure. The BCI experience with utilization, once an independent physician becomes affiliated with a hospital, has been what with respect to utilization of imaging studies, for instance?

A. We would treat the acquisition of a practice by a hospital as being the same as the physician owning the equipment because the economic incentive for them is the same.

MR. STEIN: Objection, lack of foundation.

THE COURT: The witness can testify as to how -- he said, "We would." There may be a fallacy in that economic analysis, but if that is what BCI perceives, I think it has relevant, even if it is wrong.

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Go ahead and answer. Or continue with your answer, I should say.

THE WITNESS: When we have done our modeling as an example, one of the exhibits that's come up a few times is measuring the cost increase if the Nampa ancillary services are billed, stopped being billed from the Nampa providers and start being billed by the hospital. We did not assume those services would increase in utilization. So we eliminated whatever vagary that might have created and said let's assume the same number of services happened, even though we think there would be an increase, and that 32 and 40-whatever-percent increase is based on no change in utilization.

BY MR. POWERS:

Q. Are you familiar with BCI's utilization tracking with respect to Treasure Valley Hospital?

A. I don't recall seeing, that I personally seen anything recently specifically for Treasure Valley.

Q. Is that a subject that Dr. Coleman is familiar with at Blue Cross?

A. He may be.

Q. Thank you.

THE COURT: Now, Mr. Stein, is there anything you want to ask as a follow up?

MR. STEIN: Just briefly.

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RECROSS-EXAMINATION

QUESTIONS BY MR. STEIN:

Q. Mr. Crouch, you don't know how the Saltzer physicians were compensated, if at all, for ancillary services that they ordered when they were in independent practice; is that right?

A. I don't know the specifics.

Q. And you don't know the terms of their compensation with St. Luke's, including how their compensation may or may not be affected by the ordering of ancillary services now; is that correct?

A. That is correct.

THE COURT: Anything else, Mr. Greene?

MR. GREENE: Nothing more from us, Your Honor. We do have a few minutes if you want to start the video.

THE COURT: We are going to have use the time. I assume the witness is excused and will not be recalled. Is that accurate, Counsel? Do any of you intend to recall Mr. Crouch?

MR. STEIN: I don't believe so.

THE COURT: Thank you, Mr. Crouch.

Call your next witness.

MS. MORAN: Your Honor, what we'll be doing is playing a portion of the video.

THE COURT: Counsel, we will go just a few minutes

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beyond. I assume you will be willing to waive the reporting of the playing of the videotaped deposition. However, to do so, we need to have a clear record as to what was played and what the Court considered. So either there has to be a designation filed. And I know there are objections, which I suggest and I think Counsel has agreed, I will just reserve ruling on those until I actually review and we determine -- we will include a decision on the objections in our final decision on the matter. But is there a designation that has been filed as part of the record?

MS. MORAN: It will be, and this actually includes both the plaintiffs' designations plus the counter designations by the defendants back and forth. So we will have a designation sheet for Mr. Metcalf as well so he knows that.

THE COURT: You will be willing to waive reporting of the playing of the deposition?

MS. MORAN: Yes, Your Honor. We have a deposition that was filed that is marked as well.

MR. STEIN: To waive the reporting of the playing of the deposition?

THE COURT: Yes.

MR. STEIN: Yes.

MR. GREENE: Yes.

MR. POWERS: Yes.

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THE COURT: Thank you. Ms. Yant appreciates that I'm sure. Counsel, if you will just indicate.

(Video deposition of SCOTT CLEMENT published.)

THE COURT: Why don't we take a break, pick back up in about two minutes, and resume with the video in two minutes. No reason this cannot be played while -- the courtroom can be open to the public or is this also --

MS. DUKE: It can be open to the public. The only exhibit is 1997.

THE COURT: We can note any media are free to come into the courtroom.

****** COURTROOM OPENED TO THE PUBLIC ******

MR. STEIN: We have one deposition-related matter, Your Honor.

THE COURT: If it is not going to take long. I have a sentencing later this afternoon I need to get ready for. If it is something we can do in a brief period of time, that would be fine.

MR. STEIN: Only because it impacts depositions that are going to be played. There are a very limited number, I think three depositions, where both sides have made affirmative designations. Most depositions of the witnesses so counter-designations, overlap coming up tomorrow or the rest of this week. We would like to have our affirmative designations and the plaintiffs' counters.

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We would like to have all the testimony from that witness played at the same time because we think without a live witness, the dynamic of cross-examination is going to result in duplication if we have one set of designations now and then we have overlapping designations later.

We followed basically the principle that I think Your Honor set forth in the pretrial order. So as long as our affirmative designations are roughly similar to our counter-designations being a proxy for cross and direct, that we would like to have those played all at the same time and in the same order for the Court, especially given the time pressures we are under.

MR. ETTINGER: Your Honor, we have a different view. I guess I am a little foggy. I remember we had a detailed discussion I believe before Mr. Metcalf and maybe it was not resolved.

My view is we are entitled to present our case as our case and there is no convenience of the witness issue here. It is all on videotape. And that St. Luke's can then, if they want to, present part of these depositions as part of their case. I don't think there is going to be significant duplication involved.

THE COURT: I thought we dealt with this in a pretrial order. Mr. Metcalf, do you recall?

We'll resolve this tomorrow morning. I guess my

inclination is to, since there are no -- the primary reason I require counsel to cooperate and allow a witness to cover on cross-examination what counsel would otherwise have to cover by recalling as part of their case in chief is primarily convenience of the witness. Without that, then it would seem to me, consistent with Mr. Ettinger's view, that a party should be able to designate who they want and how to present it in their case in chief.

The only exception I would think to that is substantial overlap and to avoid having to play 25 minutes twice, then I think that is something we ought to just indicate when it is played the first time because it has been cross-designated. Then it won't have to be replayed as part of the defense case unless the defense wants to replay it for whatever reason. I guess the beauty of that is it is self-policing because you are using your own time. If it is worth it to you, then more power to you, and if it is not, it won't be.

That is my general thoughts. We will take up tomorrow morning and you probably ought to assume that will be my ruling. I want to check the pretrial order, and if I indicated something else, I probably erred because my intent was only to do that with live witnesses and not on deposition excerpts.

Recess until 8:30 tomorrow morning.

(Whereupon, evening recess taken.)

REPORTER'S CERTIFICATE

I, Lisa K. Yant, Official Court Reporter, County of Ada, State of Idaho, hereby certify:

That I am the reporter who transcribed the proceedings had in the above-entitled action in machine shorthand and thereafter the same was reduced into typewriting under my direct supervision; and

That the foregoing transcript, pages 213 to 445, contains a full, true, and accurate record of the proceedings had in the above and foregoing cause, which was heard at Boise, Idaho.

IN WITNESS WHEREOF, I have hereunto set my hand October 31, 2013.

-s-

Lisa K. Yant
Official Court Reporter
CSR No. 279